

**Constructing Families and Kinship through Donor Insemination:  
Discourses, Practices, Relationships**

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Katrina Hargreaves**

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## ABSTRACT

This thesis explores the complex web of social relations created by the use of donor insemination (DI) in Aotearoa/New Zealand. The experiences of pursuing parenthood and creating a family using this method of assisted conception are contextualised through attention to the practices of Donor Insemination Programmes and the discourses used by parents, their families and health professionals. Sociologists and other social scientists have drawn attention to the social and cultural consequences of the fragmentation of biological/genetic, gestational and social parenting that follows the use of third party gametes. This thesis explores the implications of these procreative arrangements for the meanings attached to cultural concepts such as 'kinship', 'family', and 'parenthood'. Variation in the way these families respond to issues associated with the use of donor sperm in the conception of a child is also highlighted. The thesis also explores the dominant discourse in the New Zealand context of children's 'right' to know their genetic origins, and how this is played out in the perceptions and actions of health professionals, parents of children conceived by DI and their kin.

The research is exploratory and qualitative, drawing on semi-structured interviews with parents, grandparents, aunts and uncles of children conceived by DI, and with health professionals working in DI programmes. The inclusion of the perspectives of extended family members and health professionals constitutes a unique contribution to research on families with children conceived by DI. The secrecy, anonymity and confidentiality that have surrounded DI practices have long hindered the study of families with children conceived by DI. Despite a trend towards information-sharing in DI in New Zealand, the thesis shows that for these families, patterns of secrecy and disclosure are complex, variable and embedded in particular social and relational contexts.

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## PART ONE

### **Setting the Scene**

## Chapter One

### Contextualising Conception

Whereas “the birds and the bees” described a natural process, inaccessible to human intervention, occurring deep inside the woman’s body, and unfolding according to the laws of nature, the new narrative of assisted or achieved conception tells a different story. This world becomes visible and knowable through technological means, creating new forms of accessibility to and improvement of reproduction (Franklin, 1995:333).

#### Introduction

This thesis explores the discourses, relationships and practices associated with the conception of a child or children through donor insemination. Donor insemination (DI) is the most commonly used form of third party conception<sup>1</sup> in the field of assisted human reproduction (AHR). Although usually considered one of the ‘new’ reproductive technologies, the use of DI as a medical ‘treatment’<sup>2</sup> for male factor infertility has a relatively long history, dating back at least to the turn of the nineteenth century in Europe (Bateman Novaes, 1998:108-110). In New Zealand, anecdotal evidence suggests that DI has been practised by medical practitioners at least since the 1940s (Watkin, 1998; Daniels, 1999a). DI is a relatively simple procedure compared with other more ‘high tech’ methods of assisted conception. It involves the production of a semen sample from a male ‘donor’<sup>3</sup> through masturbation. The donated semen is later inseminated into a recipient woman through either intracervical insemination (ICI), or intrauterine insemination (IUI). Before the advent of cryopreservation (the ability to freeze living tissue, including semen) fresh semen samples were used in the insemination. Today,

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<sup>1</sup> Third party reproduction refers to procreative arrangements that involve using the genetic material (sperm and/or oocytes or embryos) of persons outside a primary relationship. For example, a couple who is intending to have a child, but who is unable to provide the viable sperm and/or eggs (gametes) themselves, may opt to use gametes provided by an anonymous donor or a person known to them.

<sup>2</sup> Whether DI can legitimately be considered a ‘treatment’ for infertility is debatable. It does not cure infertility, and the person with the problem (the male) is not the one who is ‘treated’. While infertility is defined as a ‘couple’ problem by the medical profession (Dickens, 1990:23-24), the female body becomes the focus of fertility treatment which is carried out with the aim of assisting a couple to achieve the goal of conception and the birth of a child. See Chapter Six for a discussion of DI as a ‘treatment’ for male factor infertility.

<sup>3</sup> Inverted commas are used here because it is not always clear whether gametes have literally been given without financial recompense, or whether financial incentives were involved in their procurement. See discussion on the use of language in this thesis appearing later in this chapter. See also Chapter Five for discussion on the construction of the provision of semen as a gift.

however, regulatory bodies such as the Reproductive Technologies Accreditation Committee (RTAC), the accrediting body for Australian and New Zealand fertility clinics, require that cryopreserved semen only be used in DI.<sup>4</sup>

The use of DI as a means of conception needs to be considered in the wider context of AHR generally. Developments in the field of AHR, particularly since the birth in 1978 of the first baby conceived by in vitro fertilisation (IVF), have introduced unprecedented scientific/technological possibilities for conceiving and bearing children. Medical science has not only enabled the separation of biological reproduction from sexual relations; human conception now has been achieved *outside* the human body. Moreover, the use of third party gametes in assisted conception introduces further complexities by enabling the splitting of male and female reproductive roles. As a result, at the extreme, the possibility exists for a child to have five individual parents, instead of the ‘usual’ two.<sup>5</sup> Use of these reproductive technologies has therefore added new social and cultural dimensions to the meaning both of human procreation and of family and parental roles. As discussed in Chapter Three, ‘old’ assumptions about the ‘natural’ processes of procreation can no longer be taken for granted as the foundation of kin relations and the formation of families (Strathern, 1992b).

Medically-assisted forms of conception using third party gametes include donor DI, egg donation, embryo donation and surrogacy. Although these methods of reproduction constitute a very small part of all AHR, and a fraction of all human births, their existence is nonetheless highly problematic and controversial because they challenge foundational understandings about human reproduction, and the formation of families. Consequently, the possibilities afforded by these reproductive arrangements have far-reaching social implications, not only for the families created in this way, but for all people, including the state.

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<sup>4</sup> See RTAC Guidelines, Attachment J, 12.1, in Appendix D.

<sup>5</sup> Assisted conception using the gametes of third parties expands the possibilities of the number of ‘parents’ a child may have. For example, in the case of surrogacy, five ‘parents’ may be involved in the procreation and subsequent rearing of a child: sperm donor, egg donor, gestational mother, social father and social mother. In this case, the first three persons are constituted as having genetic or biological ties to the child, and the ‘social’ or adoptive parents as having social but not genetic/biological ties to the child. As discussed throughout this thesis, biological, social and legal parenthood can be separated or combined. See Chapter Eleven for a discussion of parenthood in the context of DI.

The moral, ethical and legal issues that arise as a result of the social complexities that emerge from third party reproduction have been strongly debated in twentieth century western society. The new social dimensions have long been recognised within ethics, law and theology, and governments have largely sought their enlightenment on the possible consequences of AHR from these sources (Stacey, 1992). The Catholic Church takes the position that the use of third party gametes in AHR is morally wrong, on the basis that it intrudes a third party into the 'sacred' domain of marriage (Lauritzen, 1993). Critics of DI have likened the practice to adultery and question the ethics of the production of semen used in DI through masturbation. Speculation about the ethics of using DI arises in connection with the possible harm it might cause the parties who participate in these reproductive arrangements (Alpern, 1992). Other ethical concerns revolve around the moral status of human gametes and zygotes (fertilised eggs), the ethics of embryo research, and issues concerning the potential commodification of human life through the commercialisation of reproductive services, most notably, commercial surrogacy, and the sale of human gametes (Wasserman and Wachbroit, 1992).

The law plays an important role in regulating and controlling AHR in different societies. Legal debates about AHR concern major social issues such as the legal status of the parents and the children that are born as an outcome of third party reproduction. High-profile court cases contesting the custody of children born through surrogacy arrangements<sup>6</sup> have highlighted the concerns about filiation, or parentage, that emerge (Shenfield, 1994), and whether such procreative arrangements are in the 'best interests' of the children so born (Heyl, 1988). Legislation in the United Kingdom and New Zealand has helped to clarify the status of the child born through third party reproduction. The legal status of the child conceived through DI was clarified in English law by the Family Law Reform Act 1987, and the Human Fertilisation and Embryology Act 1990 (Morgan and Lee, 1991). The latter Act stipulates that the consenting husband/partner of the woman who is inseminated is to be treated as the father of the resulting child (Morgan and Lee, 1991:155). Children born as a result of DI in circumstances where the husband/partner of the woman has not consented to the treatment are considered to be legally 'fatherless', which is a newly-created class of child (Morgan and Lee, 1991:156).

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<sup>6</sup> The so-called 'Baby M' case in the United States in the late 1980s is the most notable example (Oliver, 1992).



In New Zealand, the Status of Children Amendment Act 1987, the only piece of legislation specifically addressing AHR<sup>7</sup> (Caldwell and Daniels, 1992), was formulated to absolve sperm donors of parental rights and responsibilities, and recognise the husband/partner of the recipient woman as the legal father of the child conceived by DI. In the case of egg donation, the gestational mother is almost universally recognised as the legal mother (Shenfield, 1994). As discussed where relevant throughout the thesis, many other countries have enacted similar legislative provision.

In recent years, social science has been acknowledged as making a valuable contribution to shedding light on the social and cultural implications of new reproductive techniques (Stacey, 1992). Contributions to the debates surrounding the use of DI have come from a number of social science disciplines including psychology, psychiatry, social work, sociology and social anthropology. Psychological studies on the use of DI have included studies on the psychological impact of infertility on couples and the types of loss associated with it (Adler and Boxley, 1985; Domar, Zuttermeister and Friedman, 1993; Mahlstedt, 1994), and the psychological distress associated with fertility treatment and treatment failure (Cook et al, 1989; Boivin et al, 1995). Other studies have focused on the psychosocial wellbeing of parents after assisted conception resulting in a multiple birth (Colpin et al, 1999); the meaning of parenthood and couples' reactions to male infertility (Edelmann, Humphrey and Owens, 1994); and the psychological issues associated with secrecy and disclosure for parents who have conceived by DI (Cook et al, 1989; Bielawska-Batorowicz, 1994; Klock, Jacob and Maier, 1994; Klock, 1996).

As well as studies of couples, some studies have been undertaken to understand the motivation of semen donors (see, for example, Daniels, 1989; Daniels, Lewis and Curson, 1996; Emond and Scheib, 1998). The effects on the children born as a result of DI have been a more recent focus of attention. A number of studies were published during the 1990s that evaluate the social and emotional development of children conceived by DI or other reproductive technologies (Golombok, et al, 1995; Chan, Raboy and Patterson, 1998; Golombok et al, 1999). Some of these studies also make comparisons between the

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<sup>7</sup> However, two bills currently before the New Zealand parliament, the Human Assisted Reproductive Technology Bill (New Zealand, 1996) and the Assisted Human Reproduction Bill (New Zealand, 1998), may enact further legislation in this area (Daniels, 1999a).

adjustment of children conceived by DI in lesbian-led and heterosexual families (Chan, Brooks, Raboy and Patterson, 1998; Chan, Raboy and Patterson, 1998).

Social workers, psychologists and counsellors have increasingly become involved as part of the clinical team in DI programmes, and have contributed to the growing literature on the psychosocial aspects of DI (Daniels, 1986). Much of the social workers' contribution has focused on the implications for all the parties involved in third party conception including the couple, the donor, the child and the family (Snowden and Mitchell, 1981; Snowden, Mitchell and Snowden, 1983; Humphrey and Humphrey, 1988; Daniels, 1991). In the 1980s and 1990s, concerns about the long-term psychological effects of secrecy about DI on families, and those conceived by DI, led to a growing debate about its appropriateness (Snowden, Mitchell and Snowden, 1983; McWhinnie, 1986; Baran and Pannor, 1989; Daniels and Taylor, 1993a; Landau, 1998). An increase in pleas for openness, or what has become more commonly known in the literature as 'information-sharing', has become evident in these debates (Brewaeys, 1996).<sup>8</sup> Daniels and Haines' edited publication (1998) includes chapters on specific sets of actors in the DI network including the 'users' of DI, persons conceived by DI, the semen providers, medical and regulatory frameworks. This publication encompasses perspectives from a number of disciplines including sociology, history, anthropology and social psychology (Daniels and Haines, 1998:3).

Sociologists and other social scientists recognise that assisted reproductive techniques, such as DI, are enmeshed in a complex web of social relations. Some sociologists have explored assisted reproduction in relation to biological and social notions of parenthood (Achilles, 1986; Haines, 1992), the meaning of 'family' (Haines, 1990; Achilles, 1993) and the ways in which people conceived with the use of donated gametes are represented by others (Haines, 1998). Sociologists have also examined the social context(s) within which gamete donation takes place, including issues of gender in gamete donation (Haines, 1993a) and the construction of 'infertility' as both a medical phenomenon and a social problem (Bateman Novaes, 1998). These authors have explored the ways in which meanings are attached to relationships within families, the language used to describe

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<sup>8</sup> See Daniels and Taylor (1993a) for a discussion on the issues of secrecy and openness in DI, and other authors' commentaries following in the same publication.

assisted reproduction, and the ways in which language usage actively constructs meaning and understandings about assisted conception and the different contexts within which this occurs. This thesis extends these discussions, highlighting in particular the uniqueness of the New Zealand context and the embeddedness of the experience of infertility and third party conception in wider kin relations.

This introductory chapter aims to establish the questions for and focus of this thesis. The following section locates the thesis within the key debates in the literature, emphasising the contribution it makes to these debates. The next section provides a background to the international and New Zealand contexts in which DI is practised. A discussion on the use of language and terminology in the thesis follows. The final section outlines the structure of the thesis.

### **Locating the thesis in the field of AHR**

The primary focus of this thesis is the implications for New Zealand families of having a child conceived by DI. It looks at the way that parents and their kin actively construct meaning around family and kin relationships in a situation where they have conceived a child with the use of sperm from an unknown donor. The thesis thus explores the meanings attached to cultural concepts such as ‘family’ and related concepts such as ‘fatherhood’, ‘motherhood’, ‘parenthood’, ‘kinship’ and ‘relatedness’. The study makes a unique contribution to the field by including interviews not only with parents but also with extended family members, thereby making an argument that experiences of parenting and forming a family through DI are inextricably embedded in wider kin relations.

Discussions about ‘family’ and ‘kinship’ raise questions about the merits of studying families with children conceived by DI. This question informed the study from the beginning. Stacey (1992) has argued that because the family is a fundamentally important social unit in any society, the fact that new reproductive techniques introduce novel ways of human conception and family formation warrants their investigation by social scientists. Although the number of people born through third party gamete donation is an extremely small percentage of total births (Robertson, 1994), the fact that these conceptions present a ‘deviant’ case, and the subsequent questions that this raises for the

families involved presents a topic of great social and sociological interest. A study of a subgroup of families tells us a great deal about the wider context of family and kinship patterns, which, in turn, informs understandings about how our society is organised and the extent to which diversity exists within family structures.

This research is also timely because of recent media attention to issues such as the posthumous use of semen in assisted reproduction, and also links to other topical and controversial issues such as human cloning, genetic testing and stem cell research. DI and other forms of assisted conception continually challenge cultural assumptions about what it means to be a 'parent' and the meaning of 'family'. Novaes (1989) rightly points out that as the new procreative techniques become more publicly established, in order to achieve social legitimacy, procreative and parental roles will have to be distinguished, defined and appropriately recognised. In her view, a great deal of work remains to be done in this area before the practice of using third party gametes in human reproduction can become a legitimate, socially acceptable and well understood practice.

By exploring the implications for families and their kin of having a child conceived with gametes of an unknown third party, the thesis raises questions about the meaning of biogenetic connection not only for parents, but for grandparents, aunts and uncles. It also explores issues relating to the relative importance of biological and social ties, and of belonging to a particular family, the significance of biogenetic connection to the formation of identity, and how these families perceive themselves in relation to other 'types' of family.

In addition to locating the experience of DI in the wider family context, this thesis also provides a unique opportunity to view DI in the context of New Zealand clinical practices. The study includes interviews with health professionals working in donor programmes in New Zealand. This group is considered important because, it is argued, the cultural context within which health professionals work to 'make babies'<sup>9</sup> has a bearing on how family-building through DI is conceptualised and experienced by those who conceive children in this way, and by their extended kin. The thesis highlights New

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<sup>9</sup> This idea comes from the title of a 1998 publication: *Making Babies: A New Zealand guide to getting pregnant* produced by members of Fertility Associates, a private fertility clinic in New Zealand.

Zealand's uniqueness as a small country, with a small number of fertility clinics, which have adopted an innovative approach to information-sharing in DI. For the past ten years or so, almost all fertility clinics have voluntarily adopted a policy of recruiting only semen donors who are prepared to be identified to their DI offspring at a later date.

Health professionals working in New Zealand DI programmes also encourage parents of children conceived by DI to tell their children how they were conceived. This unique approach to 'openness' was fostered by a socio-political climate that advocated that people had the 'right' to know their genetic origins. This belief was written into law in the Adult Information Act, 1985, which, for the first time, enabled people who were adopted or who had placed their children for adoption, to have access to identifying information about their birth parents/children. Advocacy of openness in adoption and assisted conception using third party gametes was also fostered to a large extent by New Zealand's biculturalism, which means that New Zealand Maori cultural perspectives are taken into consideration in the formulation of policy and practice in New Zealand society. The fundamental importance to Maori of whakapapa, or knowing one's genealogical origins, has therefore been instrumental in the development of the 'right to know one's genetic origins' as a dominant discourse in New Zealand society more generally.

Also unique to the New Zealand context is the inclusion of counsellors as central members of fertility treatment teams. This highlights a move away from the biomedical model and the adoption of a biopsychosocial model in the context of fertility treatment. Clinical treatment teams thus focus not only on the medical problem of circumventing infertility, but also actively acknowledge and engage with the psychosocial implications of their practices. Also unique to New Zealand, the adoption of this treatment model and a philosophy of openness in New Zealand fertility clinics have preceded legislation in this area. Thus, the formulation of laws currently under consideration to govern AHR practices in New Zealand, will follow policies largely already adopted by clinics.

The research and the practices being explored in this study are located in a particular socio-political context that impacts both lay and scientific understandings about AHR. The thesis therefore argues that because DI can be construed as the medicalisation of family building, the discursive and relational strategies employed by health professionals

in fertility clinics in the process of setting up relationships between donors and recipient families *rework* meanings attached to family and relatedness. In an environment relatively unregulated by legislation, clinicians have power in mediating relationships between parents and donors, donors and DI offspring, and families who share the same donors. Clinics therefore set up relationships between families linked in the process of DI conceptions, and provide the context in which parents have their first introduction to forms of relatedness achieved by DI. Attitudes and beliefs about DI that permeate the medical/treatment culture constitute the basis for shared social action (Daniels, 1999b). As a result, it is argued that the particular policies and practices of clinics, such as advocacy of ‘openness’ and the child’s ‘right to know’ their genetic origins, and the construction of semen provision as an ‘altruistic gift’, therefore influence, if not entirely determine, the way parents and their wider families will act and relate to each other.

This thesis is primarily located between the disciplines of sociology and anthropology. Social anthropological theorising about kinship and relatedness are central to the thesis. It draws on the work of anthropologists such as Schneider (1968 [1980]; 1984), and Strathern (1992a; 1992b) who have highlighted the centrality of biogenetic connection in Euro-American ideas about kinship. In the 1990s, several social anthropologists made a significant contribution to the literature on AHR by highlighting the cultural implications of the use of reproductive technologies including DI (see, for example, Strathern, 1992a, 1992b; Edwards, Franklin, Hirsch, Price and Strathern, 1993, 1999; Ginsburg and Rapp, 1995; Franklin, 1997; Franklin and Ragone, 1998). As discussed in Chapter Three, these authors argue that understandings about the meaning of ‘natural’ procreation have been destabilised as a result of the use of reproductive technologies, and that this has implications for understandings of kinship and human relatedness. This thesis contributes to and extends the discussion of the complex implications of DI and AHR generally for the meanings people give to concepts such as ‘family’, ‘parenthood’, ‘fatherhood’ and ‘kinship’, and challenges the notion that kinship ties emerge straightforwardly out of biological ties based on the ‘natural facts’ of life.

In addition to focusing on social anthropological theoretical concerns about kinship, this exploratory, qualitative study also contributes to arguments about diversity, change and fluidity in contemporary Western families. Discussion about relatedness in families using

DI is framed in this thesis by recent sociological theorising about families that recognises family diversity, fluidity and change. These discussions reject the idea of ‘the family’ as a fixed, unitary concept and static societal institution (Morgan, 1996; Silva and Smart, 1999; Smart and Neale, 1999). The thesis draws on the notion of ‘family practices’ (Morgan, 1996) which focuses on the interiority of family relationships, gendered practices and adult-child relationships, rather than ‘the family’ as a pre-given structure. Discussion and analysis therefore highlight the relational and dynamic aspects of families, rather than positing a model of ‘the family’ as a static societal institution. The thesis also engages with an eclectic interdisciplinary literature in relation to particular themes.

As outlined in Chapter Two, the thesis is primarily based on the analysis of interview material gained from semi-structured interviews with parents of children conceived by DI, their extended kin, and health professionals working in two DI programmes in fertility clinics in the South Island of New Zealand. The study is national to the extent that research participants were drawn from areas as far south as Southland and as far north as the Bay of Plenty. Analysis of information gained from interviewing people on one occasion necessarily provides a ‘snapshot’ view of people’s retrospective perceptions of their experience from a particular point in time. Nevertheless, the richness of the interview material is testimony to the depth of insight that people have gained from the processes of interpreting their own lives and accounting for their own actions and the actions of others.

This sociological study extends the discussion in a field that is under-theorised. The study does not attempt to test a theory or develop a theory; rather it draws upon literature both within and outside the field of AHR as interpretive and analytical tools. It emerges at a time when there is a great deal of interest in ‘family’ and an acknowledgement of the variety of family forms that exist in contemporary western societies. This research and the practices being explored in this study are located in a particular socio-political context which impacts on both lay and scientific understandings about AHR. Current issues in AHR therefore need to be understood in relation to national and international practices that are medical, legal and political. The following section provides background information about DI practices both internationally and within the New Zealand context.

### **Donor insemination: the international and New Zealand contexts**

The use of DI as a means of circumventing male infertility has a relatively long history in the context of AHR. According to Daniels (1998b:78), the first reported use of donor sperm in artificial insemination<sup>10</sup> occurred in the United States in 1884 though the incident was not reported in the medical literature until 1909. As previously mentioned, anecdotal reports in New Zealand suggest that some doctors, as early as the 1940s, assisted women with infertile husbands to conceive (Watkin, 1998; Daniels 1999a). The practice, however, has largely been shrouded in secrecy because of religious, moral and legal concerns about this method of conceiving children. New Zealand's first recognised donor programme was established in 1972 at Auckland's National Women's Hospital (Watkin, 1998:18; Daniels, 1999a) and similar programmes were also opened in Wellington and Christchurch in the 1970s. Secrecy and anonymity, however, remained paramount concerns. In the attempt to protect the identity of donors, many of whom were sourced within medical schools, these early donor programmes kept no records, and recipient couples received only minimum information about the donor (such as hair colour and eye colour only).

In the 1980s many countries reported increasing use of AID by medical professionals (Daniels, 1985). Ostensibly, this was prompted by social and technological factors including advances in gynaecological technology, the decline in numbers of children available for adoption, and increased public awareness of AID as a result of growing media attention to the issues and controversies surrounding the practice (Daniels, 1985:235). Despite growing use of this form of conception internationally, DI continued to be performed in an *ad hoc* manner within an unregulated environment. To preserve anonymity between the parties to a DI conception, few practitioners kept records of inseminations which could link donors and recipient families, and recipient couples were advised to keep the nature of their child's conception a secret, even from the child him/herself.

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<sup>10</sup> Until recently, DI was commonly known as artificial insemination by donor (AID). The reasons for the shift in terminology are explored in the next section of this chapter which examines language usage related to AHR.



Internationally, it is difficult to ascertain the extent of the use of DI and the numbers of children born, and how many families include a member born through DI, because few countries maintain statistics on DI. According to Daniels and Haines (1998:2), Britain and France are the only countries that maintain accurate DI statistics. In 1994, 1,805 babies were reported to have been conceived through DI in the United Kingdom and, in 1991, 1,777 babies were born in France after DI ‘treatment’ (Daniels and Haines, 1998:2). Other countries, such as Australia, New Zealand and the United States, collect data on AHR, but separate statistics on DI are not included. Estimates are made: for example, Daniels (1985) estimated that one child a week born in New Zealand was conceived as a result of DI.

Much of the language used in relation to AHR has stressed its technological aspects, highlighting the dominance of the scientific/technological/medical professions in the field (e.g. in vitro fertilisation (IVF), artificial insemination by donor (AID), and assisted reproductive technologies (ART)). Human reproduction using assisted reproductive techniques was, and still is, seen as a way of reproducing ‘artificially’, as opposed to ‘naturally’. According to Bateman Novaes (1998:108), the abbot and scientist Lazzaro Spallanzani (1729-1799) carried out initial experiments in the artificial insemination of frogs and dogs to determine the role of eggs and the ‘little animals’ (sperm) in semen in reproduction. Early accounts in the literature refer to ‘Artificial Impregnation’, ‘Artificial Insemination’ or ‘Human Artificial Insemination’, the latter differentiating it from artificial insemination of other animals. References were also made to the ‘Artificial Family’<sup>11</sup>. The terms ‘artificial insemination by husband (AIH), and ‘artificial insemination by donor’ (AID) were widely used, and still are to some extent, to refer to the medicalised procedure of inseminating a woman with either her partner’s sperm, or the sperm of a donor.

Some changes in terminology usage have occurred as a consequence of increasing debate about the social implications of assisted procreation, and with the increasing contribution

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<sup>11</sup> These terms were taken from articles and books as follows: Hard, A.D. (1909) Artificial Impregnation. *Medical World*, 27:163; Lamson, H.D., Pinard, W. J., and Meaker, S.R. (1951) Sociological and Psychological Aspects of Artificial Insemination with Donor Semen. *Journal of the American Medical Association*, 1:14; Kraus, J and Quinn, PE (1977) Human Artificial Insemination: Some Social and Legal Issues, *Medical Journal of Australia*, 1:19; Snowden, R & Mitchell, G.D. (1981). *The Artificial Family*. London: George Allen & Unwin.

of the social sciences to the field. More recently, for example, the term ‘artificial’ appears to have lost favour, particularly with social scientists, as the most useful or accurate way of assigning meaning to new medicalised ways of conceiving a child with the aim of creating a family. The term ‘artificial reproduction’ has therefore been replaced with terminology such as ‘assisted human reproduction’ (AHR), ‘assisted conception’ or ‘assisted procreation’. Similarly, artificial insemination by donor, or AID, has been replaced by the term ‘donor insemination’, or the acronym DI. A variety of factors appear to have contributed to this language, for example, the move towards using ‘people first’ language in a bid to acknowledge the people involved in these procreative arrangements. Moreover the shift from using the acronym AID was advocated to differentiate it from AIDS (acquired immune deficiency syndrome).

Growing developments in the broad field of AHR over the past two decades have raised concerns in many countries about the need to formulate policy and legislative frameworks to govern its use. The development of public policy and legislation concerning the use of DI therefore needs to be seen in the context of policy on AHR more generally. Both internationally and in New Zealand, this process has been somewhat *ad hoc* and piecemeal. Questions continually arise as to how much state control should be exercised in the area of AHR, and mechanisms used to address the ethical, legal, and political issues raised in this context vary between countries (Blank, 1998). Initiatives to regulate DI have primarily come out of reports of various commissions and committees established by governments to report on the complex issues associated with AHR. These include the Warnock Committee in Britain (1984), the Waller Committee in Australia, and the Baird Commission in Canada (1993) (Blank, 1998:139).

In New Zealand, increasing concerns about the moral, legal and social implications afforded by new reproductive techniques, and the lack of a regulatory framework, fuelled developments in this area in the mid-1980s. In 1984, a powerful professional group, representing the Royal Society of New Zealand, the New Zealand Law Society, the Medical Council of New Zealand and the New Zealand Medical Association, lobbied the government to appoint a standing committee to consider the legal, moral and social issues arising from IVF, artificial insemination and related ‘new birth technologies’ (Daniels and Hargreaves, 1997:2). The group believed that a review of AHR and a monitoring

process was necessary (Coney and Else, 1999). The birth of New Zealand's first 'test-tube' baby at National Women's Hospital was announced in the same year. Also in 1984, the first survey to determine the extent of the practice of AID was carried out in New Zealand (Daniels, 1985). This survey revealed a diversity of views and practices among practitioners. For example, of the 20 obstetricians and gynaecologists who responded to the survey, 9 (45%) thought it desirable that a child conceived through AID be told of his/her origins; 30% thought it undesirable; and a quarter (25%) were unsure whether or not it was better for the child to be told (Daniels, 1985:237). The same study revealed that seven practitioners (35%) kept no records that could link a donor and a recipient couple, and six (30%) set no limit on the number of children to be conceived per donor (Daniels, 1985; Coney and Else, 1999:4).

In 1985, the first action by the New Zealand government with regard to addressing the issues relating to AHR took place. The Law Reform Division of the New Zealand Justice Department published an issues paper, *New Birth Technologies*, which aimed at encouraging New Zealanders to decide on acceptable options in this area, and to make submissions (Department of Justice, 1985). A follow-up document, of the same name, summarising the 164 submissions received was published the following year (Department of Justice, 1986). Almost a quarter of the submissions referred to the need for a 'watchdog committee' to oversee assisted reproductive technologies (ART) in New Zealand (Daniels and Hargreaves, 1997; Coney and Else, 1999:4). However, the author of the 1986 Justice Department report noted that there was no consensus on the status and purposes of such a committee (Department of Justice, 1986). According to Daniels and Hargreaves (1997), this was perhaps understandable given the lack of consultation between the various groups and individuals involved.

In response to the submissions received, however, the New Zealand Department of Justice established an Interdepartmental Monitoring Committee on Assisted Reproductive Technologies (IMCART) with representatives from several government departments. The committee was to act as a repository for information about ART, monitor developments, and advise ministers. Its function was therefore reactive, rather than proactive (Daniels and Hargreaves, 1997). In the same year, the Status of Children Amendment Act 1987 was passed. This was a significant piece of legislation in the

evolution of the practice of DI in New Zealand because it clarified the legal parentage of children born as a result of DI. The husband of the woman inseminated with donor sperm was to be recognised in law as the legal father, and the donor had no rights and responsibilities vis-a-vis the child. This development drew comment at the time that the law was misnamed because it established parents' rather than children's status (Daniels, 1999a). This is the only piece of legislation in New Zealand that addresses any aspect of AHR.

Although there have been calls from within both the medical and legal professions to introduce adequate regulatory frameworks for the practice of AHR, as in other countries, the New Zealand Justice Department has been reluctant to legislate in this highly complex and contested domain. Growing unease about the lack of a legislative or policy framework, prompted an AHR service provider, Fertility Associates, in 1990, to invite the Reproductive Technology Accreditation Council of Australia (RTAC) to review and accredit their clinic. Later, RTAC became the accreditation body for all New Zealand fertility clinics (Daniels and Hargreaves, 1997). This initiative may have been influenced by the establishment of the Human Fertilisation and Embryology Authority (HFEA), a clinic licensing authority in the UK.<sup>12</sup> Amidst growing concern at the time about issues related to surrogacy and the use of donor eggs in assisted reproduction, the Medical Council commissioned a review of AHR by the University of Otago Bioethics Centre. *Biotechnology Revisited* was published the next year (Medical Council of New Zealand, 1991). Fifty responses to the report were received, many expressing concern about the professional capture of ART, and professional self-regulation (Daniels and Hargreaves, 1997:3).

Concerns about the possible need for a regulatory framework for the practice of AHR in New Zealand were instrumental in the establishment of the Ministerial Committee on Assisted Reproductive Technologies (MCART) in 1993. One of the Committee's terms

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<sup>12</sup> The HFEA is the British licensing body established by the Human Fertilisation and Embryology Act 1990 to regulate AHR. This body "is the most comprehensive attempt to regulate ART anywhere in the world" (Coney and Else, 1999:5) Among other things, the Authority is required to operate a licensing system for all centres who use treatments involving the use of donated gametes. The Authority is obliged to maintain a central registry containing information on all children born and all gamete providers. One of its statutory duties is to publish a Code of Practice which is issued to all clinics to provide guidance on all aspects of licensed activities. This Code is to be reviewed regularly to ensure that it remains relevant to contemporary society (Blank, 1998).

of reference was to find out what was happening in the field of AHR. With this in mind, the report of the Canadian Royal Commission on New Reproductive Technologies, *Proceed with Care*, published in 1993, was cited as an important source for informing debate. With contributions from over 40,000 individuals, this 1,300 page report was considered by the Committee to be “the most exhaustive examination of the issues surrounding assisted reproduction anywhere in the world” (MCART, 1994:25). In their 1994 report to the Justice Department, the two-person New Zealand Committee recommended against legislating to establish a licensing scheme similar to that established in the United Kingdom. Instead, the Committee recommended the establishment of a Council for Assisted Reproduction to act in an advisory and overseeing capacity (MCART, 1994). The report set out a number of major recommendations with regard to the provision of DI services, including the rights of all parties involved and the establishment of registers. An Officials Committee, established in 1995 by the New Zealand Justice Department to consider the MCART’s proposals, recommended against the establishment of a Council. Instead, it suggested that the National Ethics Committee on Assisted Reproduction (NECAHR)<sup>13</sup> take on some extra tasks. The direction of policy on AHR in New Zealand is yet to be determined pending the outcome of discussion about the bills currently before parliament. In the meantime, however, NECAHR has become the *de facto* policy-making body for AHR in New Zealand, particularly in the area of surrogacy (Daniels and Hargreaves, 1997:4).

In the bid to introduce a legislative framework for AHR in New Zealand, in 1996, Labour MP, Dianne Yates introduced to parliament a Private Member’s bill designed to formulate a legal framework for restrictions and controls on assisted reproductive technology in New Zealand. The Human Assisted Reproductive Technology Bill (New Zealand, 1996) was modelled on British, Canadian and Australian legislation. The main points of the bill were to licence clinics, to keep centralised records, prevent cloning, and

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<sup>13</sup> NECAHR was initially established by the Ministry of Health as the Interim National Ethics Committee on Assisted Reproductive Technologies (INECART) in 1993. At that time, the establishment of an ethics committee specifically for AHR was in response to the difficulties experienced by regional ethics committees in connection with assisted reproduction protocols (Daniels and Hargreaves, 1997). INECART was responsible for declining ethical approval for applications from fertility clinics to perform IVF surrogacy on two occasions in 1993 and 1994. Objections to this decision came from both the legal and medical professions. INECART was reconstituted as NECAHR in 1995. In 1997, the committee approved the practice of gestational surrogacy in principle. The following year it approved the first case and provided draft criteria to clinics for future applications (Coney and Else, 1999:8).

outlaw the sale of babies and body parts/tissue/fluids. The bill had a second reading in 1997, but it was not until late 1998 that the government finally introduced its proposed legislation. The Assisted Human Reproduction Bill (New Zealand, 1998) prohibits ‘unethical’<sup>14</sup> techniques, provides rights of access to information to both gamete donors and children born through third-party reproduction, and “affirms and slightly expands the role of NECAHR” (Coney, 1999a:26). Of particular relevance to the use of third party gametes in AHR, the bill prohibits payment for human gametes and embryos, and it stresses a policy of ‘openness’, setting up a central registry of information about donors of gametes and children born as a result of third party reproduction. The bill, however, “falls short” of establishing a strong regulatory body to oversee AHR in New Zealand (Coney, 1999a:28).

Specific issues relating to the practice of DI, addressed by official bodies assigned the task of evaluating AHR procedures in their respective countries, include access to DI services, screening and payment of gamete donors and issues of record-keeping and information-sharing. An analysis of the social policy and legislative responses to AHR reveals that at least thirty-five countries have implemented either legislation, regulations, or guidelines relating to DI practices (Blank, 1998:139). Few countries have enacted legislation to ban DI, and most have laws that address the legal status of the DI child, so that he/she is considered a legal child of the ‘social’ father.

Many countries limit access to DI to heterosexual couples. In New Zealand, however, the Human Rights Act 1993 makes it illegal to discriminate on the basis of age, marital status or sexual orientation (MCART, 1994:14). In 1994, the Human Rights Commission ruled that Fertility Associates, Auckland, could not legally refuse DI for single women, nor could this clinic refuse DI for a Maori woman, with a Pakeha partner, using sperm from a Samoan friend (Coney and Else, 1999:7). These occurrences prompted both Fertility Associates and the Human Rights Commission to call for greater regulation of assisted reproduction. Despite concerns expressed by health professionals<sup>15</sup> and the public<sup>16</sup>

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<sup>14</sup> ‘Fundamentally unethical activities’ include the cloning of humans, fusing of animal and human gametes, implantation of animal or human embryos in the opposite species, and the use of human cells to develop procedures or techniques for undertaking any of these activities (Coney, 1999a:26)

<sup>15</sup> According to Daniels and Burn (1997), a number of health professionals are reported to be concerned about delivering AHR services to groups such as single, lesbian or post-menopausal women. In 1995, a scientist resigned from Fertility Associates, citing her disagreement with the Human Rights legislation

about creating ‘fatherless families’, increasing numbers of single and lesbian women are accessing AHR services in New Zealand (Daniels and Burn, 1997).

According to Blank (1998:144), about 50% of the countries that regulate DI practices, require donors be screened for sexually transmitted diseases and/or genetic disorders. This is the practice in Australian and New Zealand DI programmes which adhere to the guidelines for screening gamete donation established by the Fertility Society of Australia (MCART, 1994). Payment of gamete donors is a particularly contentious issue because of arguments against the intrusion of the market economy in the ‘sacred’ area of human life, and concerns about the commodification of children<sup>17</sup>. The problem of recruiting sufficient donors to meet recipient needs has often led clinics to offer financial incentives to attract potential donors. Sperm donors are paid for their services in several countries including the United Kingdom, the United States and Japan (Blank, 1998:140-141). Other countries pay donor ‘expenses’ which circumvents the ethical dilemma of paying for human genetic material. In New Zealand, donors have been offered some kind of financial incentive to donate semen, particularly when a student population is targeted. Currently, however, most clinics eschew paying donors, preferring an ‘altruistic’ to a ‘commercial’ model. Nonetheless, donor recruitment remains a perennial problem for donor programmes in New Zealand, and in almost all countries.

The issues of record-keeping and information-sharing between the parties involved in DI conception remain highly controversial. Most countries which have addressed the issue of DI in depth require some form of record-keeping but, for most, retaining donor anonymity is a paramount concern (Blank, 1998). Some governments, however, have taken the view that it is in the donor offspring’s best interests to be able to access identifying information about the donor. Sweden was the first country to enact legislation stipulating that donor offspring had the right to learn their donor’s identity upon maturity (at no set age). This move, according to Daniels and Lewis (1996b), was fiercely opposed

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which resulted in these groups gaining access to ART (Daniels and Burn, 1997:81; Coney and Else, 1999:8).

<sup>16</sup> A recent survey of public opinion conducted by Heylen Research Ltd. found that the majority of New Zealanders believed that lesbian couples, single women and women past the age of menopause should *not* have access to assisted reproductive services (Daniels and Burn, 1997).

<sup>17</sup> For arguments about the merits and pitfalls of applying a ‘commercial’ or an ‘altruistic’ model to the recruitment of gamete donors, see Daniels and Lewis (1996a), Daniels and Hall (1997) and Daniels (1998). See also, Chapter Five of this thesis.

by many Swedish health professionals who argued that forcing donors to be identifiable would lead to a shortage of sperm donors. In 1992, Austria instituted legislation similar to Sweden's (Daniels and Lewis, 1996b:58). According to Daniels (1997), the state of Victoria in Australia has introduced legislation to ensure that donor offspring have access to identifying information about their donor. Switzerland (1998) has also recently implemented similar legislation and Holland is in the process of following the same legislative path. No other jurisdictions have written this requirement into law, but some, like the State of Victoria, in Australia, require that a central register is maintained, containing non-identifying information accessible to the parties involved. Identifying information is made available with the consent of the party inquired about (Blank, 1998:146).

In contrast to the Swedish situation, where legislation determined that information-sharing was provided for by ensuring that records were kept, in the late 1980s New Zealand fertility clinics began *voluntarily* to move towards a policy of 'openness' with regard to exchange of information between the parties to a DI conception. Currently, almost all clinics accept only those donors who are willing to be identified at a later date. Thus, the consensus is that, as in open adoption, it is in children's best interests to be able to identify their biological/genetic parents. As discussed in Chapter Nine, New Zealand is considered a world leader in information-sharing between the parties to a donor conception. The trend towards information-sharing in DI can be related to the social climate of a particular era in New Zealand history. According to Daniels and Lewis (1996b:65), MCART attributed the move towards openness in AHR to a "new era of openness" after the opening up of adoption records, made possible by the passing of the Adult Information Act in 1985. The committee evaluated the arguments for and against openness in AHR and determined that 'openness' was the best policy for the New Zealand context (MCART, 1994; Daniels and Lewis, 1996b).

MCART's (1994:27-34) guiding principles were formulated recognising the need to protect the rights and responsibilities of both partners, Maori and non-Maori, in the Treaty of Waitangi, 1840.<sup>18</sup> Many of the submissions MCART received from individuals

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<sup>18</sup> The Treaty of Waitangi, 1840, represents an agreement between the colonising British Crown and the leaders of the indigenous Maori tribes of New Zealand. The Treaty, which sets out the rights and



and organisations also advocated the need to respect both Maori and non-Maori beliefs and values. The issues surrounding AHR are complex for Maori, and vary across whanau, hapu and iwi (Dyall, 1999).<sup>19</sup> It is not known how many Maori currently seek infertility services in New Zealand, but one 1992 study revealed that a clinic reported that 8.8% of its clients were Maori (Dyall, 1999:37).<sup>20</sup> Many more Maori may wish to seek assistance to conceive but issues relating to knowledge about infertility services, and the costs involved, may limit access for some, particularly because Maori are disproportionately represented in the lower socio-economic groups.<sup>21</sup> Where infertility is concerned, many advocate the traditional Maori form of adoption or the sharing of kin, known as whangai, as a preferred method of family formation (Dyall, 1999:36).<sup>22</sup> Furthermore, for Maori couples experiencing male infertility, accessing donor sperm from Maori donors is problematic. In an unpublished paper, Daniels and Tau report that five New Zealand DI programmes reported considerable difficulties recruiting Maori donors. Only one couple included in my study had used a Maori donor. This couple had waited for six months for the clinic to obtain semen from a Maori donor from another part of the country.

An important guiding principle for MCART was ‘the right to know one’s genetic origins’ (MCART, 1994:32; Daniels and Lewis, 1996b:60). This principle is particularly relevant to Maori because of the cultural importance of knowing one’s whakapapa, or genealogy. The committee argued that, although not accepted by some countries, the right to know

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responsibilities of the Crown and the indigenous people, must be consulted in all public policy and legislative decision-making.

<sup>19</sup> The whanau is the basic unit of Maori society: an extended family group consisting of up to three or four generations living together in a group of houses. The hapu (sub-tribe) is the basic political unit in Maori society, consisting of a number of whanau. A number of related hapu constitute an iwi (tribe) (Ministry of Justice, 2001:30, 32, 34).

<sup>20</sup> This close to the percentage of Maori in New Zealand’s total population. In the 1991 census, 9.7% of the New Zealand population identified as Maori (Statistics New Zealand, 1992:17).

<sup>21</sup> A report to the Minister of Maori Affairs on progress towards closing social and economic gaps between Maori and non-Maori in New Zealand claimed that “Maori continue to experience poorer health status, lower income levels, higher unemployment, higher rates of prosecution and conviction, lower educational status, and lower rates of living in owned homes than non-Maori” (Te Puni Kokiri, Ministry of Maori Development, 2000:10).

<sup>22</sup> The recent approval by NECAHR of a proposed surrogacy arrangement within a Maori family has sparked controversy in New Zealand because the surrogate would be carrying her brother’s genetic child. This has led to concerns that NECAHR was approving of a procreative arrangement bordering on incest. However, Maori advisors, who were consulted by the ethics committee, argued that, for Maori, it was acceptable for close relatives, including brothers and sisters to assist each other in such situations because the child “is seen as being part of the whole whanau”(Maling, 2001).

genetic origins was important in the New Zealand bi-cultural context. In its report, the committee stipulated:

[K]nowledge of whakapapa allows Maori to access constitutional rights and cultural strengths. Pakeha also recognise that biological origins are very important for some people as they discover their own identity (MCART, 1994:33).

The philosophy of information-sharing practised in New Zealand clinics also extends to the recipient families. As discussed in Chapter Seven, although anonymity between the parties is initially preserved, recipient couples are informed that their donor offspring have the right to seek identifying information about their donor at some time in the future. Donor profiles with non-identifying information about the donor are sent to recipient couples after their child is born; this includes information about the donor's views on potentially being approached in the future. Donor insemination programmes advocating information-sharing have been in existence in New Zealand only since the late 1980s, so children conceived by DI who have the ability to receive identifying information about their donor are currently approximately 13 years old or younger. As discussed in Chapter Ten, although some instances of donors and donor offspring meeting have been reported in New Zealand, it is not yet known how many DI offspring will seek identifying information about donors, or wish to meet them when they reach the age of 18 or more.

### **Language and terminology**

Language, or discourse, is both substantive and active (Gubrium and Holstein, 1990). In terms of substance, we can think of the language or terminology used to describe AHR as a resource for both naming a process or particular technique, and for identifying what is involved in the particular technique. For example, 'donor insemination' names a particular procedure and also indicates that reproductive material from a third party is used in the attempt to achieve conception. Discourse relating to AHR is *active* in the sense that it communicates particular political/professional interests, and knowledge claims. A medical practitioner uses language that conveys his/her technical or biomedical expertise in the field. In contrast, a counsellor or social worker uses language that emphasises the social outcomes of assisted reproduction, such as the formation of families, and the impact on human relationships that emerge as a result of assisted reproduction. The choice of language used has a *political* component, and therefore will

be shaped by how a ‘speaker’ positions him or herself or is positioned vis-a-vis other protagonists in the field. Some feminists, for example, who position themselves as critics of medical intervention in reproductive processes, use language that highlights the clinical, technological, and controlling aspects of what they refer to as “new reproductive technologies” or NRT (see Wacjman, 1994).

As well as conveying meaning about the technological processes involved in assisted reproduction, terminology used in AHR, to a limited extent, encompasses the social relationships that emerge through these processes. Snowden, Mitchell and Snowden (1983) raise the important issue of the need to establish an appropriate vocabulary for ‘artificial reproduction’. These authors argue that the language of adoption - birthmother, birthfather - is not suitable to describe situations where there is a separation between a genetic and a carrying mother (Snowden, Mitchell and Snowden, 1983). Nor is it appropriate in the context of DI, where children are not born into one family and relinquished to another. The English language does not yet contain the appropriate words to describe split biological/gestational/social parent-child relationships. Snowden, Mitchell and Snowden (1983) contend that it is not sufficient to use words that merely describe the techniques involved in artificial reproduction: if we are to explore and define the social implications of AHR fully, these processes need to be understood in terms of the social relations in which they are embedded. They argue that an appropriate vocabulary should therefore encompass and accurately describe the *techniques* used, the *roles* played by the parties involved in the procedures and the *relationships* between the people (Snowden, Mitchell and Snowden, 1983:27).

Not surprisingly, this task is complicated not only by the complexity of the technical processes afforded by assisted conception, but by the number of parties that are potentially introduced into new reproductive arrangements. The separation of reproduction and sexual intercourse in assisted conception means that the reproductive process can be broken down into several discrete parts, each of which may be performed by a different individual. We can no longer assume that a ‘mother’ and a ‘father’ are the [biological/genetic and social] parents of a child. For example, as a result of processes such as IVF, egg donation and surrogacy, the role of ‘mother’ can be broken down into three different processes: the production of an ovum, the gestation of a foetus and the

raising of the offspring. Similarly, the role of ‘father’ can be split in two: the provision of the sperm to achieve the conception of a child, and the raising or nurturing of the child. Snowden, Mitchell and Snowden (1983:32-35) therefore propose a “suggested nomenclature” that would describe the roles of the parties in the reproductive process. They identify seven different roles associated with ‘motherhood’ including the genetic mother, carrying mother, nurturing mother, genetic/carrying mother, genetic/nurturing mother, carrying/nurturing mother. The ‘complete’ mother would combine all three roles/stages. In relation to ‘fatherhood’, the terms genetic father, nurturing father and complete father are suggested.

From this we can see that defining ‘motherhood’ is a more complex task than defining ‘fatherhood’. Nonetheless, where DI is concerned, the possibility for (at least) two ‘fathers’ exists.<sup>23</sup> The genetic father is the gamete donor, and the nurturing father is the husband or partner of the woman who is inseminated and bears the child. In this situation, the ‘nurturing’ father is positioned next to the ‘complete’ mother. The authors contend that ‘complete’ is not meant to signify the quality of parenting, but merely the fulfilment of all possible reproductive roles. It nonetheless conveys a sense of ‘more than’ or ‘better than’ a position which fulfils only part of all potential reproductive/parenting roles. The extensive and complex set of terms suggested by Snowden, Mitchell and Snowden (1983) does not appear to have been used extensively in the literature. Yet their attempt to come up with a set of terms to describe varying mothering and fathering roles with somewhat more precision is noteworthy because it raises the unanswerable questions of ‘Who is the mother?’ and ‘Who is the father?’ In one way or another, all can potentially be called ‘the mother’ or ‘the father’. It should be noted, however, that these questions reflect a social, ‘taken-for-granted’ assumption that we all have only *one* mother or father. All others are qualified (e.g. mother-in-law, adoptive mother, foster father, and so on) (Cameron, 1984:304, 320).

Discussion of terminology associated with AHR, and the language used to define assisted reproductive procedures and persons involved in or created by these procreative arrangements, is discussed at relevant points in the thesis. At this stage, however, I shall

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<sup>23</sup> See Chapter Eleven for a discussion about fatherhood in the context of DI. See also Chapter Ten for the language used by parents of children conceived by DI when referring to their sperm donor.

indicate some of the main words or terms I use throughout this thesis, and why I have chosen them. I generally prefer to use terms that give primacy to the human aspects rather than the technological. For example, I refer to assisted conception or AHR rather than new reproductive technologies (NRT) or assisted reproductive technologies (ART). This appears particularly relevant in DI, which, unlike many other procedures, is not a ‘high-tech’ method of assisting conception.

While some authors refer to sperm donors as ‘semen providers’ to avoid implying whether or not semen providers were paid (see Daniels, 1998b), I prefer to use the term ‘donor’. This seems appropriate in the New Zealand context, where, as discussed in Chapter Five, semen provision is generally constructed as an altruistic gift. I also refer to donors as ‘genetic parents’ or ‘genetic fathers’, not to imply a potential social relationship between donors and their DI offspring, but because donors are the progenitors of such offspring. Questions arise in connection with the appropriate terminology for referring to the children or people who have been born as a result of assisted reproduction generally, and DI in particular. A person conceived by DI is often referred to in the literature as an ‘AID child’ or, more recently, a ‘DI child’, or a ‘donor child’.<sup>24</sup> Some researchers have argued, however, that the term ‘child’ tends to infantilise persons born as a result of DI, and neglects their later adult status (Haimes, 1992). These researchers therefore prefer the term ‘offspring’ which has no age connotation. Yet others prefer the phrase ‘DI adoptee’ (Cordray, 1995), placing DI in the realm of adoption. In this thesis, when referring to DI offspring, I prefer to use the phrase ‘children conceived by DI’. This avoids reductionist labels such as ‘DI child’. I generally refer to people conceived by DI as ‘children’ or ‘individuals’ because the children of participants in this research were all 12 years and under when the interviews took place, and were therefore children rather than adults.

Finally, when distinguishing between ‘biological’ and ‘social’ parents, I variously use the words ‘biological parent’ or ‘genetic parent’ because often these words are used interchangeably, or the term ‘biological/genetic parent’, which encapsulates the broader idea of the biogenetic connection between persons. The lack of an adequate nomenclature for those who are conceived by DI and the parties to the DI conception,

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<sup>24</sup> See Haimes (1998) for the ways in which ‘the DI child’ has been represented and labelled.

particularly donors and social fathers, is discussed in more detail where relevant in the thesis.

### **The structure of the thesis**

The thesis is divided into three parts. The first part, entitled “Setting the Scene”, includes three chapters: this introductory chapter, a methodological chapter, and a chapter that reviews the main theoretical underpinnings of this research. This chapter has introduced the research project by framing the study and establishing the research context. The second chapter examines the processes of knowledge production that underlie this thesis. Highlighting the importance of reflexivity throughout the research process, I locate myself in the field of inquiry emphasising my positioning as both an ‘insider’ and an ‘outsider’. I examine my positioning as someone with a particular experience of ‘family’, a consumer of fertility services, and a student and researcher in the fields of infertility and AHR. I also outline the processes involved in choosing this research topic, gaining ethical approval, entering the field, accessing participants and carrying out interviews, attending to the ethical issues, and analysing the interview material.

Chapter Three examines how discussion about changing families and family practices provides a context for the analysis of networks of DI relatedness. Drawing on recent sociological theorising about family diversity and family practices, and social anthropological theorising about kinship in the context of assisted conception, the chapter explores the social construction of kin and family ties. It looks at social anthropological concerns about ‘nature’ and ‘biology’, and the relationship between the ‘biological’ and the ‘social’, ‘nature’ and ‘nurture’. In particular, the chapter explores the way in which analytical opposition between these sets of concepts has been destabilised. Illustrations of the permeability of these dualisms are provided in analysis of the talk of parents of children conceived by DI and family members who both construct and deconstruct these oppositions as they talk about the meaning they give to DI in their families.

Part Two examines the ways in which DI practices are negotiated. The first chapter in this section, Chapter Four, attends to the pathways to donor conception. It looks at the critical moments, the contingencies and the processes, involved in making the decision to conceive a child in this way. The chapter draws on recent sociological theory on the

constitution of narrative identity and the production of selves to examine the impact of the discovery of male infertility, and the decision to conceive by DI, on couples and extended family members. It examines couples' reflections on the options for embarking on the 'project' of parenthood, including adoption, ICSI, considering a known, rather than an anonymous sperm donor, and ultimately the choice to use DI, which led to the conception and birth of a much-wanted child or children.

The following three chapters examine the clinical context in which DI takes place. Chapter Five looks at DI practices in the context of two particular New Zealand DI programmes, and how the relationships are set up between fertility clinics, donors and recipients of donor sperm. The chapter examines the discursive strategies used to construct semen donation as an altruistic 'gift', the recruitment and screening of donors, record-keeping and the complexity of donor anonymity in a context in which children may want to access information about genetic fathers. The chapter also focuses on issues of choice and control and the rights of the various parties in the DI programme. Chapter Six examines in more detail the politics of access to DI treatment. It argues that fertility clinics are contexts for the construction of selves, which leads to the cultural examination of the clinical context. In connection with issues of access, it examines the barriers encountered by prospective recipients resulting from the availability of donor sperm, and the implementation of clinical policies and procedures in relation to who are considered 'suitable' for parenthood. Chapter Seven presents an analysis of the processes of DI 'treatment', outlining and examining the protocols and procedures involved in having DI treatment. It looks at the types of information provided to recipients, contact between recipients and clinical staff and counsellors, the experience of inseminations, pregnancy and the birth of a child, and follow-up with DI programme staff.

Part Three of the thesis includes four chapters that explore the negotiation of relationships within families (including extended family) and between families and outsiders after having a child conceived by DI. Chapter Eight discusses the issues of secrecy and disclosure, examining the complex and often contradictory processes involved in decisions to tell or not tell others about DI. It examines the range of practices with respect to 'information-sharing' that were evident in families with children conceived by DI, and how these are embedded in sets of social relations. Chapter Nine focuses on the

issue of telling the child about his or her DI origins, and the argument about the ‘right’ of the child to know this information. It looks at clinical practices with regard to advocating that children be informed about how they were conceived, and parents’ attitudes and actions with respect to telling or not telling their children. Chapter Ten explores the ways that parents and kin of children conceived by DI think about the sperm donor. It explores the attitudes of recipients and their kin attitudes, their perceptions of donors and their levels of interest in those who have donated their sperm. Chapter Eleven examines families with children conceived by DI in the context of family diversity and change. It illustrates that parents who are using DI to conceive do so in a context of general ‘troubling’ of what we understand by families in a world in which children are less likely to live with their genetic/biological fathers.

Chapter Twelve, the concluding chapter, sums up the main arguments of the thesis. It provides an overview of what this study contributes to knowledge about the implications for families of having a child conceived by DI, and how this, in turn, contributes to understandings about families and relatedness more generally at the turn of the twenty-first century.



## **Chapter Two**

### **Exploring family connections: the research process**

[T]he most admirable thinkers within the scholarly community ... do not split their work from their lives. They seem to take both too seriously to allow such dissociation, and they want to use each for the enrichment of the other.... What this means is that you must learn to use your life experience in your intellectual work.... In this sense craftsmanship is the center of yourself and you are personally involved in every intellectual product upon which you may work (C. Wright Mills, 1959:195,196).

#### **Introduction**

This chapter examines the social processes involved in carrying out this exploratory, qualitative study. In recent years, reflexivity has been given increasing attention by ethnographers and other social researchers, many of whom have produced ‘natural histories’ or ‘research biographies’ (Hammersley and Atkinson (1995:17, 22). A reflexive approach recognises that the researcher is part of the social world that she or he is studying, and that the research is shaped by her or his values and interests, thus highlighting that social research cannot be value-free (May, 1993; Smith, 1975). Advocating critical autobiography as social science, sociologists, such as Church (1995:3, 5) have emphasised the ‘private’, ‘personal’ and ‘emotional’ dimensions of their projects as a way of writing about and penetrating the world they are creating/inhabiting as a researcher. By beginning from ‘I’, the researcher does not abdicate a commitment to what is ‘public’, ‘theoretical’ and ‘rational’; rather he/she acknowledges that what one presents of oneself as subjective and personal is simultaneously objective and public (Church, 1995:4).

Bearing in mind the importance of reflexivity in the research process, the chapter encapsulates more than the rather standard account of the research methods chosen. It begins with a discussion of my location in the field of study. I locate myself both as part of a particular ‘family’, which attached certain values and meanings to ideas about ‘family’, and as a person who has experienced ‘infertility’ and the use of conceptive technologies. I also situate myself as a student and as a researcher who has pursued a particular academic path, which led me to carry out this particular

study. I consider the ways in which I was both an ‘insider’ and an ‘outsider’, and identify my shifting and changing positions during the process of carrying out this research, as both a researcher, and ‘consumer’ of fertility services. I also pay attention to the contingent processes that led to my carrying out this sociological research. The research methods chosen, the processes of entering the field, negotiating access to participants, and the challenges and obstacles encountered in my research ‘journey’ are also a focus of attention. The chapter also discusses the ethical issues involved in doing qualitative research about ‘sensitive’ areas of social life: in this case, male infertility and issues connected with conceiving by ‘alternative’ means. The final section explores the on-going and time-consuming processes of organising and interpreting the data in order to write the thesis.

### **Locating myself in the field**

My own experience of being part of a ‘family’ and my experience of infertility and the use of reproductive technologies have provided useful resources for undertaking this research and interpreting the interview material. As Pahl (1995:196) has argued, when one is doing research one is often thinking about one’s own life as much as the life of others. The meanings I myself attach to concepts such as ‘family’, and related concepts such as ‘fatherhood’, ‘kinship’ and so on, are embedded in my personal experience of being part of a particular family and extended kin group. At times during the course of this research, I have had to question these, particularly when confronted by meanings or interpretations that contradict my own. This has been a rewarding and enriching aspect of doing this research.

I was born during the post-war baby boom and brought up in a family of six children. The family structure resembled the ‘traditional’ nuclear family in that my father was the breadwinner and my mother the full-time unpaid mother and homemaker. But it did not conform to the ‘norm’ of the nuclear family, in that, for the first nine years of my life, we all lived in one half of my maternal grandmother’s large house. She was the much-loved ‘matriarch’ in an extended family dominated by ‘strong’ women. Our grandmother was a pivotal person in our lives, and through her we were aware of a connection to a vast kinship network. My grandmother had been born into a wealthy rural family, with a wide network of kin relations. Her father was the fifth of seven

sons, all of whom owned large sheep and cattle stations throughout the South Island of New Zealand towards the end of the nineteenth century. Extended family was thus an important feature of our lives.

We grew up surrounded by stories of my family history and kin connections: who had married whom, and who was related to whom. My mother, who has a particular interest in her family genealogy, has written and published a book detailing the lives of her maternal grandfather and his six brothers. A large circular family tree beginning in the centre with her great-grandfather and great-grandmother who had immigrated from Scotland with their seven sons in the mid-1800s hangs on her wall. Now in her late 70s, my mother continues to make connections with kin in various parts of world.

Family history and genealogy were not only important to my mother; my father too was knowledgeable about, and proud of, his family origins. He had immigrated to New Zealand from Denmark as a young man and, although he loved his adopted country, he strongly identified as a Dane and we, his children, grew up identifying as ‘half-Danish’. Through my father, I developed a strong sense of my Danish ancestry, and as soon as I left high school I chose to learn more about it by living there for six months with my paternal uncle and his family. This paternal uncle recently compiled a family tree including photographs and miniature portraits of extended family members going back five generations to the late 1700s. This family tree is framed and now hangs on my wall, along with a number of artworks painted by members of my father’s family, serving as a reminder of this part of my heritage, or ‘roots’.

Growing up in a family where people were constantly making explicit references to kinship ties, we were very aware that our eldest brother had a different biological father from the rest of us: my mother had been married before she married my father. Growing up with a brother who was ‘technically’ a half-brother has provided a resource for framing biological connections ‘outside’ the family, and a knowledge of the variety of interpretations that can be used to give meaning to biological relationships where there is no social relationship, and vice versa. This gave me first-hand experience of the way in which those who are born with biological connections

to persons 'outside' the nuclear family can be constructed as both 'different' and 'special'. I recall when my brother first met his biological father, at age 18, when he was embarking on the same professional career his father had chosen. I was 12 at the time, and I remember asking him what it was like to meet his father. He said that it was like meeting someone he had always known. Yet no social relationship has developed between them.

In addition to my experience of 'family' and 'kinship', my role as a researcher is inextricably entwined with my personal experience of infertility and assisted human reproduction. I first became interested in infertility, and the variety of reproductive technologies used to circumvent it, when I failed to get pregnant myself, and embarked upon my own 'infertility journey' which ultimately led to my undertaking a series of 'unsuccessful' IVF treatments. Being positioned or positioning myself vis-à-vis research participants variously as 'researcher', 'infertility patient', and 'consumer of fertility services' raised issues about being both an 'insider' and an 'outsider' in the field of inquiry. Daly (1992:109) argues that researchers' past-related experiences demand not only acknowledgement but also conscious inclusion in the research process. This not only involved informing participants of my experiences of infertility and fertility treatment, but also acknowledging how my experiences and values emerged within the socially-constructed setting of the interview, as well as in the interpretation of the interview material.

With the aim of acknowledging my 'insider' status in the general fields of infertility and assisted human reproduction, I informed participants of my experience of infertility and IVF treatment. This raised the spectre of how segmented this field is, depending on one's infertility 'diagnosis' and method of assisted conception. As a result of this fragmentation, in the context of researching families with children conceived by DI, I felt positioned only partially as an 'insider'. I could identify or empathise with some of the issues and experiences connected with infertility. At the same time, I felt that I was not entirely an 'insider' because my 'problem' was not male infertility. Moreover, unlike my research participants, I had not experienced DI 'treatment', which raises different issues from IVF 'treatment' that does not involve the use of third party gametes. Also, unlike the parents I interviewed, I had not

become pregnant and given birth to a child as a result of clinical treatment. Thus, in some ways I felt positioned as a person ‘without a family’, in the sense that I did not have children of my own. Perhaps because of these ‘outsider’ elements, the general sensitivity of issues surrounding infertility, and my status as ‘researcher’ among the ‘researched’, my experiences of infertility and IVF treatment were seldom taken up by interviewees, particularly in the context of interviews with couples. Some women participants, however, appeared to empathise with me as a woman ‘still trying’ to conceive through assisted means; and I was encouraged to do so by one woman who assured me that it was “worth it in the end”.

I had a third IVF treatment just before beginning my PhD research, and thought at the time that that would be my last. As is often the case in fertility treatment, and confirmed by participants in this research, it is difficult to concede ‘defeat’ when the possibility of the treatment ‘working’ next time looms large. Partly encouraged by a friend’s successful IVF pregnancy, and because of my own continuing involvement in the field throughout the research process, I had one final attempt at IVF towards the end of the interview ‘phase’ of the study. Undoubtedly my experience of fertility treatment has been a resource for understanding the processes involved, and what is often referred to as the ‘emotional rollercoaster’ that generally accompanies it. My experience of failed fertility treatment helped me to empathise with those who had repeated failed cycles before finally conceiving. My particular experience of fertility treatment, however, differed from some of my participants. For example, I remember starting the IVF drug regime at a time when I was carrying out one of my last interviews, which was with a lesbian couple who had conceived through self-insemination. When I told them about the injections I administered to myself, they were intrigued by the clinical regimes that I had to go through when they had had the good fortune of being able to conceive with relative ease, through self-insemination outside the clinical setting.

My experience of unsuccessful IVF cycles, hospitalisation as a result of ovarian hyperstimulation syndrome (a potentially life-threatening situation associated with IVF treatment), and the disappointment of a series of failed attempts to conceive has, undoubtedly, made me somewhat ambivalent about fertility treatment. At the same

time, I am aware that it works for some people and, because DI is low-tech, less physically invasive, and less costly than other forms of fertility treatment, it is, according to health professionals interviewed for this research, cumulatively the most successful treatment available. Nonetheless, with my treatment history, I was a little uneasy in the clinical setting, particularly when interviewing health professionals who had been involved in my treatment process. In relation to the latter, I experienced shifts and changes in my identity from ‘patient’/ ‘consumer of fertility services’ to ‘researcher’. Illustrating this shift, on one occasion I met with the Director of a fertility clinic for an IVF consultation just a week before I had scheduled an interview with him for this research. At the end of our private consultation he commented he would be wearing a “different hat” at our impending interview. On that occasion, at the start of the interview he asked how it was for me to be interviewing couples who had had children through assisted conception. I inferred from this that he was concerned that I might find it difficult to study ‘families’ when I myself had failed to conceive. I assured him that I had no particular ‘problem’ with it, and certainly this was the case throughout the study. At times, however, I have reflected on the chanciness of human conception, and that while it was elusive for me, it certainly was not for others.

My infertility ‘journey’ ran parallel with my university studies. In the year that investigations into my infertility began, I had returned to university to complete a degree in Sociology. I enrolled for a course in Body Politics in the Sociology Department of the University of Canterbury, which introduced me to radical, liberal and Foucauldian feminist critiques of the ‘new reproductive technologies’. I was fascinated to engage with this material from my position as a woman who was contemplating and exploring the possibilities of medically-assisted conception. I later began researching other infertile couples’ experiences of infertility and fertility treatment for papers undertaken for my BA (Hons) degree. Each of the four projects I undertook for this graduate degree encompassed an aspect of assisted human reproduction, further illustrating that my personal history is deeply implicated in my choice of a field of study. One of the projects focussed specifically on donor insemination and introduced me to many of the issues for both recipient couples and donors. Information gleaned from participants in this small study raised a number of

questions that were later pursued in my thesis research. After completing my BA (Hons) degree, I gained a summer scholarship from the New Zealand Health Research Council to study aspects of the ethics of assisted human reproduction, under the supervision of one of my PhD supervisors. This also added to my location as a 'student' and 'researcher' in this area of research.

While my experience has informed my research, the research process has also influenced my personal life. I began this particular academic 'journey' anticipating that it might be interrupted at any time with the conception and birth of a child. This has not happened, and gradually it appears that the path towards parenthood has been closed off to me. This undoubtedly has been emotionally painful for me at times, but in a way the research process has helped me 'come to terms' (inasmuch as anyone fully 'comes to terms' with infertility) with not having children. I have come to see parenthood as one of many possibilities in life. On a 'good' day, I am even glad that I do not have children and the many complications and sacrifices that this entails for parents. At the same time, I still marvel at the 'miraculousness' of human conception and reproduction, the 'specialness' of the parent/child connection, and regret that this will not be part of my personal 'journey'.

### **Choosing a topic and research methods**

Preliminary discussions with one of my PhD supervisors pointed to the lack of research on families with children conceived using third party gametes. At the time, my supervisor also indicated that no research on 'DI families' to date had included extended family members as participants, so this presented an opportunity to carry out ground-breaking research, and make an original contribution to the field. Initial discussions with my supervisors focussed on the possibility of researching families with children conceived through any of a variety of procreative arrangements using third parties, such as surrogacy, egg donation, embryo donation, donor insemination, or IVF involving donated sperm and/or oocytes. Given that few people had used some of these forms of procreation in New Zealand, and particularly in the South Island,<sup>1</sup> where I was located, questions arose about the feasibility of conducting such a study. Thus the project began as a 'feasibility study' before it was taken on as a

study for doctoral research. This conservative approach to ascertaining the suitability of the topic for PhD thesis research seemed appropriate considering that it was a 'sensitive' area to research, and that similar sociological research had not been conducted before, in the field of AHR in New Zealand. Later, after some initial attempts to recruit participants, it became clear that for practical reasons, such as access to participants, the study should be confined to families with children conceived by DI and health professionals working in DI programmes.

Preliminary work involved reading widely on the topic of the use of third party gametes in assisted human reproduction, and developing a proposal to be submitted to the academic board and then to two committees for ethical approval to carry out the research. First, I had to gain ethical approval from the National Ethics Committee on Assisted Human Reproduction (NECAHR).<sup>2</sup> NECAHR was established in 1995 to provide ethical review of assisted human reproduction (AHR) in New Zealand. The committee, which operates under the Health and Disabilities Act 1993, was established by and is accountable to the Minister of Health. Its terms of reference include reviewing new, untried or innovative methods of assisted human reproduction to ensure that all ethical aspects are considered. This includes granting ethical approval for any research, including social science research, in the area of AHR (Daniels, 1998a). After NECAHR reviewed and granted approval for my research to proceed, I was granted ethical approval by the University of Canterbury Human Ethics Committee, which was contingent on my gaining approval from NECAHR.

A crucial task in the development of the research proposal is the ability to identify suitable research methods. Several researchers have identified qualitative methods as the most suitable for research on private and sensitive areas of people's lives, particularly in an area where the dynamics are not yet fully understood (Voysey, 1975; Gilgun, Daly and Handel, 1992; de Laine, 1997). Qualitative research methods are particularly useful in this type of research because they are more fluid and flexible than most quantitative research designs (Moon, Dillon and Sprenkle, 1990:359; Achilles, 1986:13). Because they are more open-ended and exploratory, they facilitate

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<sup>1</sup> In 1997, when this research began, formalised egg donation programmes were only just being organised in South Island fertility clinics, and no children had yet been conceived through this method.



a more holistic, in-depth understanding of what is happening in a particular research setting (Moon, Dillon and Sprenkel, 1990; Gilgun, Daly and Handel, 1992).

My vision for the research was humanist/interpretive, rather than scientific/positivist, which meant that I sought to develop an empathetic understanding of, or *verstehen* approach to, the meanings that people attach to their lives and their relationships (Good, 1996; Layder, 1993; de Laine, 1997). As Bryman and Burgess (1994) have pointed out, qualitative research is a dynamic process that cannot be reduced to particular techniques and set stages. According to Bechofer, it involves a “messy interaction between the conceptual and empirical world, deduction and induction occurring at the same time” (cited in Bryman and Burgess, 1994:2). This is borne out by my own experience. For example, when I entered the field, I had some knowledge of the literature on assisted human reproduction, and some of the theoretical and conceptual frameworks used by sociologists and social anthropologists that I could draw upon. I was therefore aware that certain themes might emerge in the process of data collection, and these were used to frame the interview guide and influenced my selection of particular analytical frameworks for the interpretation of the data. With these frameworks in mind, I nonetheless planned to be open to the possibility that the investigation would produce information that would disrupt the theoretical analysis that informed the research design.

The primary method of data collection was face-to-face, semi-structured interviews with couples with children conceived by DI, their extended family members, and health professionals working in DI programmes. Other data sources included a form of ‘participant observation’ as a client at a fertility clinic, and as a member and committee member of the local Infertility Society. In 1999, I became an Individual Representative on the Executive of the New Zealand Infertility Society, which enabled me to keep abreast of developments in the fields of infertility and assisted reproduction. I also attended three conferences and an information day hosted by the New Zealand Infertility Society and a symposium on medically-assisted surrogacy. Using information from a variety of sources facilitated triangulation, an important concept in qualitative research, which refers to seeking multiple sources of data to

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<sup>2</sup> In 1995, the Interim National Committee on Assisted Reproductive Technologies (INECART) was

enhance the validity and reliability of the research ‘findings’ (Moon, Dillon and Sprenkle, 1990:361; Macdonald and Tipton, 1993).

I chose face-to-face semi-structured interviews as the primary method of data collection because it appeared to be the best method of collecting information about complex, personal and sensitive areas of peoples’ lives (Fielding, 1993). According to Fielding (1993:137), in-depth interviewing is frequently used by qualitative researchers aiming to explore people’s attitudes, beliefs and values. This form of data collection worked well for exploring the meanings that people attach to taken-for-granted concepts such as ‘family’, ‘parenthood’, ‘fatherhood’, and ‘motherhood’, because it elicited people’s talk around these concepts, and enabled an examination of the discourses they drew on to make sense of these in their day-to-day lives. Family researchers working in the area of infertility and fertility treatment have used qualitative methods successfully to explore a wide range of fertility and parenting experiences (see, for example, Sandelowski, Holditch-Davis and Harris, 1992; Daly, 1992). My previous experience of carrying out semi-structured interviews with couples for projects carried out for my BA (Hons) degree had provided me with some relevant interviewing skills.

Questions arose as to whether I should interview couples with children conceived by DI together or separately. After considering the benefits and possible pitfalls of both formats, I decided to interview couples together.<sup>3</sup> Daly (1992:107), who chose this method, argues that “parenthood is usually contingent on a *shared* construction of reality” and therefore interviewing couples together was the best way of trying to capture this. Other advantages of conjoint interviews were that spouses/partners can jog each other’s memory and tend to keep each other honest, which were important for establishing reliability and validity of the data (Daly, 1992). Although conjoint interviewing allowed for the possibility of disagreements or unanticipated disclosures, both of which occurred to a limited extent in my research process, the interaction between the couples provided insight into the couple’s relationship, and was a rich data source (Sandelowski, Holditch-Davis and Harris, 1992). Interviewing couples

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reconstituted as NECAHR (Report of INECART, December 1995).

<sup>3</sup> See Daly (1992) and Sandelowski, Holditch-Davis and Harris (1992) for pertinent discussions about the advantages and challenges of conjoint interviewing.

was also useful in the recruitment process, because typically men are reluctant to participate in research involving discussions about the ‘sensitive’ topic of male infertility (Achilles, 1986; Lloyd, 1994, 1996).

In all, I carried out 52 interviews for this study. Nineteen of the interviews were with heterosexual couples with children conceived by DI, though one male partner declined to participate. I interviewed one mother of children conceived by DI who was also a consumer representative for the fertility clinic accrediting body. Three separated or divorced women, each with one or two children conceived by DI, are also included. I also interviewed a lesbian couple who had used self-insemination methods of conception, and their gay male donor, and another lesbian couple who had conceived through a fertility clinic DI programme. Fourteen interviews with extended family members, and 12 with health professionals were also completed. Children conceived by DI were not interviewed specifically for this study,<sup>4</sup> though some informal discussions with children took place in the context of interviews with their parents or after such interviews. I did not set out to marginalise children; rather I did not feel that I possessed the necessary skills to interview young children, many of whom were too young to understand, let alone talk about abstract concepts such as genetic, biological or social ties. Almost all of the parents included in this study had children who were younger than 12 years old, and many were pre-schoolers or babies.

### **Negotiating access**

The secrecy, anonymity and confidentiality that surrounds DI has hindered sociological research on families with children conceived by DI (Achilles, 1986). Secrecy has led to difficulties identifying families with children conceived by DI as a specific ‘population’ in any society. Consequently, I could not select a random sample from a population of DI families, and then generalise from my ‘findings’ to the particular population. Furthermore, for ethical reasons, participants were necessarily ‘self-selected’ because only those willing to speak about this ‘personal’ and ‘sensitive’ area of their lives are included in the study. This raises questions about the ‘representativeness’ of my sample. I make no claims about its

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<sup>4</sup> Another New Zealand researcher, Dr Vivienne Adair, an educational psychologist and Director of the Centre for Child and Family Policy Research at the University of Auckland, New Zealand, has carried

representativeness in the statistical sense of the word. Nevertheless, a degree of representativeness can be attributed to it given that the discourses that people draw on to help them make sense of their lives, and guide their actions are constituted by common and shared social understandings (Williams and Popay, 1994:122). As a result, it can be expected that people who embark on similar experiences (e.g. having children by DI) at a particular time and in a particular place will draw on a set of discourses that are generally available to them to interpret and make decisions about their lives.

Like other qualitative researchers who aim for ‘depth’ rather than ‘breadth’ (de Laine, 1997:24-25), I aimed to discover the variety of experiences of a number of people located in different settings across the country, and to provide an in-depth analysis of these. Like other qualitative researchers, I preferred to study a few cases intensively and use criterion-based selection techniques that are suitable in research that is directed at theory-building rather than to generalising about a population (Moon, Dillon, Sprenkle, 1990:360). The general criteria for selection included being parents of a child or children conceived by DI, being an extended family member of a child conceived by DI, or working as a health professional in a Donor Insemination Programme at a fertility clinic. More specific criteria were not applied because I was not sure how easy or difficult it would be to recruit participants for the research.

Negotiating access was a key issue in the research process and raised a number of methodological and ethical issues. At times it brought to the fore the politics of doing social research. As Law (1994:vii) has pointed out: “Like life, research is the outcome of interaction.” Gaining access is crucial to the research outcome and, like life, gaining access to research sites/participants is much to do with contingency, or as Law has argued, it is to do with “what you have, what you know, *and* whom you know” (1994:37). Gaining access depended on being able to contact and get help from individuals, health professionals and social networks who had the information and power to be able to assist in the recruitment of participants. Gaining access was also to do with serendipity: chance encounters or ‘good’ timing. For example, one participant said that if he had received the recruitment letter sent to him by the fertility

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out research focusing on the implications for children conceived by DI (see Adair and Purdie, 1996;

clinic, on my behalf, a few months earlier, he would have thrown the letter in the bin, but in the event, he felt 'ready' to discuss his experiences with a researcher.

I began attempts to recruit couples who had conceived children by DI through the local Infertility Society. I contacted the president of the Society who suggested that I attend the upcoming public meeting. The meeting aimed to set up various 'interest' groups in relation to different 'treatment' options and routes to parenting (e.g. IVF, ICSI, DI, and adoption). At this meeting I juggled my identities as 'consumer of infertility services', 'would-be parent' and 'researcher'. I initially joined the adoption group because I was personally interested in this option, and it also provided a means of preparing myself mentally for the task of asking people to participate in my research. I soon switched to the donor group where I introduced myself as someone with a particular history of 'infertility', an 'IVF consumer', and also as a 'researcher' with a focus on families with children conceived by DI. I explained that I was attending the group session to recruit participants for my study, and was relieved when two women volunteered their contact details. Some days later I set up my first two interviews with them and their partners. These and interviews with some of their family members constituted the 'pilot' interviews for the study, and provided a good basis for going further afield.

One of my supervisors had connections with two South Island fertility clinics, and was instrumental in facilitating my access to these clinics. Both agreed to assist in recruiting the majority of the couples who participated in this research. The Medical Director of the local fertility clinic responded in the affirmative to my letter asking for assistance in recruiting participants, with the proviso that the clinic also benefit from the research, possibly by future collaboration in the writing and publication of journal articles. A scientist and research facilitator at this fertility clinic was my point of contact. She agreed to send out a letter from me about the research to couples who had conceived through their DI programme. She wrote a covering letter that accompanied my recruitment letter and included a form so recipients could indicate whether or not they would be willing to participate in the research.

If recipients were willing to participate, they were to send their address and contact details back to the clinic in the provided stamped addressed envelope; at the clinic's instigation, those who were not willing to participate were asked to provide a reason for their decision and also return the form. The research facilitator sent out letters in batches of 15-20, over several months, starting with couples with the oldest children. Because this particular DI programme was established in 1987, all of the children born after DI were less than 10 years old in 1998, the year I carried out most of the interviews. The research facilitator only forwarded copies of consents to me and, from the approximately 70 letters sent out to couples who had conceived through their programme, only five refusals and 11 consents were received. Over half did not respond to the letter (44), and 11 letters were returned unopened because the address was no longer current.

The low response rate raised a number of issues and questions. First, it informed the fertility clinic that they had lost contact with a number of couples who had had children through their programme, and who had not notified them of a change of address. Second, it raised the question of whether the 44 who did not respond had received the letter or not; if they had, the question then arose as to why they chose not to respond. According to the clinic's research facilitator, those who returned refusals stated either that their relationship had broken up, or that having had a child/children through DI they had 'moved on' to live life as a 'normal family' and did not wish to discuss it. In the absence of any information from those who did not wish to participate in the study, it cannot be established whether non-response can be attributed to similar or other reasons from these. This level of non-response would tend to suggest, however, that secrecy, anonymity and confidentiality still pervade the practice of donor insemination, or that many wish to avoid constructing it as an 'issue', as research on the topic might tend to suggest that it is.

As well as recruiting participants locally, I aimed to interview couples who had conceived through other DI programmes to help establish whether experiences differed between regions and clinics. To access people throughout New Zealand, I 'advertised' in the New Zealand Infertility Society magazine, *Pathways*. Four couples who had conceived children through DI programmes in clinics in Wellington or

Auckland responded to my request for participants. To interview these couples I travelled considerable distances by car in the North Island. I also contacted a nurse at one of the North Island clinics, but she declined to help me recruit couples because she had assisted another researcher, whom she claimed was doing “similar” research to my own.

With the aim of accessing participants through the other South Island fertility clinic, I had written a letter to the director to ask for his assistance. Some months passed without a response from the director, who apparently was away on leave for part of the time, and had asked a clinical nurse to send out recruitment letters for me. One of my supervisors then contacted the director, and spoke about the benefits of facilitating this research. Soon afterwards, the clinic sent out letters to ten couples, asking if they would be willing to participate in my research. Recipients were asked to contact me directly: three called me, agreeing to participate.

The difficulties involved in gaining access to participants raised a number of important methodological issues. The seemingly pivotal intervention by my supervisor highlighted Hornsby-Smith’s (1993) contention that “gaining access is a process of continual renegotiation, bargaining, and establishing trustful relations with gatekeepers and those to be studied”. It also showed that gaining access can take several months, especially if access is required to hospitals or to an institutional setting (Arber, 1993:37). It also suggested that sociological research in this area was not a priority for this and perhaps other fertility clinics, which seek to have control over research domains and outcomes that might directly affect their reputations and businesses.

The issue of control over research parameters and processes also emerged in connection with trying to access lesbian and single women who had conceived through one of the clinics. During an interview, a nurse raised concerns about the number of lesbian and single women who were going through the DI programme, which had originally been established to ‘treat’ heterosexual couples with male infertility. After the interview I contacted the research facilitator to ask if she would be prepared to help me gain access to lesbian couples and single women who had conceived through

the programme. She denied my request on the basis that “only two” lesbian couples had conceived through their DI programme, and that the children were very young, and that no single women had conceived, because most were ‘older’ and less likely to conceive. This surprised me as it appeared to contradict what two nurses had told me about the numbers of lesbian couples and single women “going through” their programme.

This response from the clinic was followed up by a call from one of my supervisors who said that the research consortium that had recently been set up through this clinic had plans for future research on lesbian couples and single women who had conceived through the programme. Thus, the clinic wanted to reserve the right to gain access to these people at a future date. This illustrated the ways in which dominant agents in a particular field attempt to protect their own interests by keeping out competition and maintaining a monopoly (Bourdieu, 1993). It also revealed the clinic’s desire to control the research process of a ‘newcomer’ to the field (Bourdieu, 1993:73). As a ‘new player’ in the field, entry to the game came with certain conditions: that I play by their rules and “pay an entry fee which consists in recognition of the value of the game” (Bourdieu, 1993:74). Perhaps because medical personnel are more familiar with quantitative methods, they expected that my study was to be confined to a particular ‘population’: heterosexual couples and their families.

With a more flexible research design in mind I, on the other hand, had wished to follow up relevant areas of sociological interest that emerged during the research process. The denial of access to lesbian parents through this fertility clinic had implications for the scope and direction of this study. I was frustrated that I was denied access to individuals who were somehow earmarked for ‘future research’ by others who were more powerfully positioned in the field. I therefore felt caught in a contradictory position. As a sociologist carrying out exploratory qualitative research on families who had children conceived by DI, I wanted to include the diversity of family forms that existed as a result of DI. Furthermore, according to the nurses on this programme, lesbian couples and single women were a significant group of clients. At the same time I did not want to alienate important gatekeepers who seemingly were not in favour of my including these other family forms in my study.



As an alternative approach, I pursued recruitment of lesbian couples through personal contacts. Through my supervisor, I gained access to a gay male donor, who had donated sperm to a lesbian couple who had conceived a child through self-insemination methods. Through him I was able to gain access to the two women. Another lesbian couple who had conceived through the local DI programme was accessed through a personal contact, who met the couple by chance at a mutual friend's wedding. The inclusion of only two lesbian couples in this study may seem like a 'token' gesture to lesbian parenting. I believe, however, that their inclusion adds a valuable dimension to the study that highlights some of the similarities and differences between lesbian-led DI families and those headed by heterosexual couples, which could be gainfully explored in future research.

### **Accessing family members**

A number of obstacles to accessing extended family members emerged throughout the research process, raising both methodological and ethical issues. To gain access to extended family members I asked couples during the interviews whether they would be willing to refer me to any family members who might be prepared to participate. The parents of children conceived by DI therefore became gatekeepers who had power to determine who else in their family I could talk to. Some were quite willing to help in the recruitment of other family members, but others were resistant.

A number of 'reasons' emerged for non-referral to family members. Some couples said they had not informed family members of their child's DI conception, so could not ask them to participate. Others had informed family members, but said that the subject was never openly acknowledged within the family, so they were not willing to raise the matter with family members. Some couples said that they had asked, but their family member declined to participate because "there was really nothing to say", and that the child was perceived as "just another member of the family": in their view, there were no "issues" to discuss.<sup>5</sup> Other couples said they would not ask their parents to participate because they believed they would not want to discuss their emotions or feelings with a researcher. One mother of a child conceived by DI was willing to

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<sup>5</sup> The perspectives of family members who took these positions would have provided relevant information on the topic being studied; these positions, however, were constructed as reasons not to participate.

participate as a way of expressing her gratitude to the clinic for helping in the conception of her son, but she did not wish to involve any other family member in the research. Some couples said they would ask family members and get back to me, but never did. In some cases, I was reluctant to follow up in case I was perceived as being overly intrusive, when they had already participated in interviews themselves. In some cases, one member of the couple implied that other family members could be approached to participate, but the other seemed doubtful; in these cases, I did not receive any referrals.

The blocks to accessing family members may be attributed to a number of factors that highlight some of the difficulties and complexities of doing family research. Many of the obstacles to gaining access relate to the ways in which having a child by DI is constructed as a 'sensitive' and 'private' issue, and to the secrecy surrounding it. Other researchers in this area have expressed concerns about the potentially negative effects of long-term surveillance or "undue vigilance" on relationships within these families (Humphrey and Humphrey, 1988:136). Issues such as male infertility and using donated sperm to conceive a child are often regarded as private and taboo subjects, which are not a topic of general family conversation. Furthermore, reproductive decisions are generally construed as the couple's private concern and "no-one else's business". Resistance to referring me to extended family members is also understandable given that family life itself is a contested domain and a site of competing discourses (Collier, 1999), and that "family relationships are as marked by friction as they are by concord" (Edwards, 1998:162).

Clearly, couples had to be comfortable with the idea of a researcher talking to other family members about their having conceived a child by DI, before they would refer me to them. As the interviewing process progressed, and after being refused access by some couples to family members, I became increasingly aware of this added 'intrusion' into their family lives. This was particularly true if the couple indicated that their relationships with other family members were somewhat strained. In some cases I did not ask to be referred to family members because I perceived a participant as particularly 'vulnerable', and I did not feel comfortable asking for a referral to a family member. My values, and 'gut feeling' thus determined the extent to which I

was prepared to pursue access to family members in the context of any particular interview. As Pahl has stated, “I am my own research instrument” (1995:196).

I also found there were barriers to gaining access to the ex-husbands or partners of women in cases of marital breakup. In each of these cases I was referred directly to the woman, or the women themselves received the recruitment letters from the clinic because their husbands had moved to other addresses. Thus, the women provided the key to access to their former partners. In one of these cases I hesitated to intrude on a relationship which appeared to be marked by significant conflict. Another participant said that she would ask her ex-husband if he would be willing to participate in the research, but I did not hear back from her. At one point during the interview, she had become tearful when recalling a time when they were still together. She called me much later about another family matter, and revealed that she and her ex-husband were no longer on speaking terms. In another case, during the interview the participant was enthusiastic about the possibility of my interviewing her ex-husband, and gave me his telephone number. I rang the number on several occasions but got no reply. Finally, a woman answered the phone and took a message, but he did not return my call. Later, I heard through a third party, that his ex-wife had “forbidden” him to speak to me, which completely contradicted her stance during the interview.

These situations illustrate the difficulty of obtaining information in an ethical manner. The failure to access these fathers has meant that only the separated/divorced women’s accounts are included in this study which necessarily gives “one side of the story”. This is unfortunate in that much past research on families has been criticised for being mother-centred rather than father-centred (Lewis and O’Brien, 1987:4). Despite this ‘gap’, however, the ‘voices’ of other fathers are clearly evident throughout the thesis, which contrasts with Achilles’ (1986) experience of researching in this area. She was able to access only three ‘husbands’ (two of whom were ‘voluntarily infertile’ through a vasectomy) for her thesis research, which she claimed reflected a general reticence in men to talk about their experience of having a child by donor insemination (Achilles, 1986:50).

Geographic distance also impeded access to some family members. To overcome this barrier I carried out three separate telephone interviews with one couple's family members who lived in different cities in the North Island. This proved to be a tactically complicated and quite expensive exercise, involving using recording equipment at the School of Journalism, which was available during the day only, and obtaining oral consent from the participants, rather than the usual written consent. One of my supervisors raised concerns about telephone interviews yielding qualitatively different data from face-to-face in-depth interviewing so, ultimately, I did not continue with telephone interviews.

### **Accessing health professionals**

In the context of this study, health professionals are defined as personnel working in fertility clinics facilitating some aspect of the operation of DI programmes. Health professionals working in two South Island fertility clinics participated in this research. These included two clinical directors, a scientist, three nurses, two laboratory technicians who also recruit donors, a counsellor, and a clinical psychologist. Additionally, I interviewed a nurse working in a North Island clinic in relation to the development of a donor family register.<sup>6</sup> These participants were all identified and contacted through their clinics. Through a personal contact, I was also able to interview a retired general practitioner who had used his own semen to inseminate one of his patients in the 1960s.

### **Ethical issues**

Appreciation of the ethical considerations in research involving human subjects has evolved over time, and often in response to scandals which have caused concern about professional ethical conduct.<sup>7</sup> As a result of such concerns, ethics committees have been established to help ensure that researchers adhere to basic ethical principles designed to protect human subjects from undue harm. These include the need to obtain informed and voluntary consent from research participants, respect for the rights of privacy and confidentiality, the limitation of deception, and the minimisation

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<sup>6</sup> See Chapter Five for discussion on this register.

<sup>7</sup> In New Zealand, the Cartwright Inquiry into unethical practices in relation to the non-treatment of women with cervical cancer is a case in point (Coney and Bunkle, 1987; Bunkle, 1988; Cartwright, 1988).

of risk to participants. Issues relating to these ethical principles pervaded all aspects of this research, and had to be attended to throughout the process.

Carrying out research on families with children conceived by DI involved examining particularly sensitive and personal areas of people's lives, highlighting the need to pay attention to the ethical issues at stake. Qualitative family researchers, Larossa, Bennett and Gelles (1981) point out that certain aspects of the family as an institution in our society make it important to seek and maintain informed consent. These include the pervasiveness of family life; the inaccessibility of family life; the physical setting in which qualitative research is undertaken (usually the family home); and the resemblance of qualitative family research to therapy (Larossa, Bennett, and Gelles, 1981). Added to these considerations is the fact that many activities of families are considered private (i.e. no-one else's business), as well as being inaccessible.

Interviews took the form of guided conversations that aimed to elicit frank, and well considered, rather than "glib or easy answers" (Fielding, 1993:138). I chose to carry out semi-structured interviews which would allow participants the flexibility to discuss areas of particular relevance to them, but would also ensure that major topic areas were covered (Fielding, 1993). I developed an interview guide that set out these main areas of questioning and identified probes to solicit more information, if and when necessary. Three main versions of the interview guide were developed: one for parents with children conceived by DI, one for family members and another for health professionals. The health professional interview guide was modified according to the particular role in the DI programme.<sup>8</sup>

Interviews with couples and family members generally took place at their homes, and most interviews with health professionals took place in fertility clinics. All interviews were taped and later transcribed. In line with the requirements of ethical committees, including the National Ethics Committee on Assisted Human Reproduction (NECAHR), I prepared an information sheet<sup>9</sup> that was presented to research participants before the interview began. The information sheet emphasised that the researcher was aware of the private and sensitive nature of the topic, and that

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<sup>8</sup> For copies of the interview guides, see Appendix A.

participants were free to withdraw from the project at any time. Confidentiality and anonymity for all participants was assured, and contact details for all those involved, including my supervisors, were supplied. Participants read the information sheet before signing the consent form, and all were given the information sheet to retain for future reference. None of those who participated later revoked their consent.

Before interviews began, I informed participants of the areas of questioning and then followed my interview guide. Semi-structured interviewing allowed for some flexibility in the direction the discussion took, but digressions were often initiated by participants who chose to focus on a particular aspect of their experience. They were also urged to talk only about issues/topics that they felt comfortable divulging to a researcher. I informed participants that they were entitled to receive a copy of the interview transcript, and return it to me with any desired changes. Few participants requested a copy of the interview transcript, and only one returned the transcript to me with any additions or modifications. This occurred on an occasion when the microphone battery on my tape-recorder had run low, and I had found it difficult to hear some of the taped interview.

Given the sensitive and private nature of the topic, it was important to be alert to possible harm caused to participants in the research. It was difficult to anticipate what ethical issues might arise during the course of an interview. To some extent I assumed that the element of self-selection in the recruiting process would eliminate those who would find the interview unduly stressful or an unwelcome intrusion into their lives. Nonetheless, I was aware that some male participants were ambivalent about participating, raising the spectre of possible coercion by their partners. On other occasions children conceived by DI were themselves present at the interview at their parents' invitation. This may have resulted from parents' interpretation of my recruitment letter which indicated that I was seeking to interview "other family members", which they had perceived as meaning members of their 'nuclear' family. I was ambivalent about the presence of young children, wondering whether it was in their interests to be party to the interviews. At the same time, I believed it was their

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<sup>9</sup> See Appendix A for copies of information sheets for participants and the consent form.

parents' decision to have them attend, and it provided me with some opportunities for unplanned data gathering.<sup>10</sup>

Some incidents that emerged during interviews suggest that while qualitative family research can be both helpful and therapeutic, problems arise when the researcher is perceived as a therapist, counsellor or an expert able to provide answers (Daly, 1992:110-111). Like Daly, I had to be careful not to over-step the bounds of my professional expertise as a researcher without professional therapy training. I was aware of this when couples clearly disagreed about matters such as whether to, or when to, tell the child about his/her origins. In such instances, I acknowledged that the issue was complex, but that only they could decide what was best in their situation. In some interviews where it became clear that the participant had some issues they wished to address, I referred participants to a trained counsellor or clinic psychologist working in the field who had agreed to assist. Some participants asked if I could help them establish contact with the local support group for couples with children conceived by DI,<sup>11</sup> and I was able to do this with the appropriate prior consent.

Given the 'sensitive' topic discussed during interviews, it is possible that participants were left feeling 'abandoned' or vulnerable after 'opening up' to a researcher. Although it is not entirely possible to erase the unequal power relationship between the 'researcher' and 'researched' (Stacey, 1991), I tried to treat participants as collaborators in important social research, in an area where little is known, and endeavoured to foster an atmosphere of trust and openness between us. After each interview, I wrote to thank participants for their contribution to the project, and said I would keep them informed of its development. I have since mailed out letters to participants, informing them about the project's status; I will also let them know when the thesis is completed and tell them how they can access it through the University of Canterbury Library.

The issue of who stands to benefit from this research must also be considered. Many participants with children conceived through DI expressed the desire to participate in

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<sup>10</sup> Chapters Ten and Eleven include some brief comments made by children conceived by DI.

research that might help others in a similar situation. They also wanted to contribute to a greater knowledge base that would inform members of society about donor insemination, thereby taking it “out of the closet”. Many participants were also interested in finding out about the lives of other DI families, and therefore wanted to read the completed thesis. Health professionals who participated in this research also expressed an interest in the psychosocial implications for donor families. The question arises, then, as to how information is disseminated to these groups in order for them to benefit from the knowledge produced. This could be achieved through presentations to interested groups, and through publications in magazines, newspapers and academic journals. These matters will be discussed further after completion of the thesis.

### **Analysing the data**

The dual tasks of organising and interpreting data coming out of 52 interviews, each lasting an average of 1½ hours was on-going and time-consuming. This, at times, brought home to me Lareau’s comment that “qualitative work is more cumbersome and more difficult than survey research at almost every stage: formulation of the problem, access, data collection, data analysis, and writing up the results” (1996:231). At the same time, as Lareau also comments, qualitative research may be the only way to gain insights into routine events in everyday life and the meaning that makes social reality: hence its value in sociological inquiry (1996:232). As Tesch points out, qualitative analysis is done in almost constant interaction with the data (1990:113). This interaction took place initially during the process of interviewing, writing up interview notes, and hearing the taped interviews while transcribing them word for word. Through constant interaction with the data I began to identify major themes. Many of these were pre-determined in the sense that they reflected questions appearing on the interview guide, which themselves emerged from knowledge about the debates and issues at the forefront of the academic literature on DI. As well as these, some unanticipated themes emerged from the interview material.

As a further step in familiarising myself with the interview material, I read through each transcript listing major themes emerging in each to get a sense of the

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<sup>11</sup> Some regional infertility societies run support groups for parents of children conceived by DI.



commonalities and diversity that existed. In retrospect, and in light of my use of NUDIST software in the data analysis process, this step may not have been necessary. At the time, however, I thought I needed to be very familiar with what I had before I could develop a workable index system in NUDIST. Subsequently, I learned that the flexibility of the programme enabled whatever reconfiguring might be necessary along the way. Reading through each transcript, however, gave me a good sense of the whole, which Tesch (1990:142) suggests is important when developing an organising system, particularly for unstructured qualitative data.

As those who teach people how to use NUDIST software themselves have stated, the best way to get to know the programme is to use it (Qualitative Solutions and Research Pty Ltd, 1994:6). I decided to use this programme for organising and aiding the interpretation of data because I thought it would save time on cutting and pasting, and endlessly flicking through transcripts manually. Rather than saving time, however, using NUDIST mainly served to organise the manual activities of organising data differently, say, from a cut-up-and-put-in-folders approach (Tesch, 1990:128). NUDIST provided the facility to both store data documents and index them according to major themes and subthemes, which are called ‘nodes’. For example, I labelled the first node “Pathways” as a way of identifying aspects of the data that related to the lead up to conceiving a child by DI. Subsequently, this and the many sub-nodes that emerged from this ‘parent’ node were interpreted and used to formulate Chapter Four: Pathways to Donor Insemination.

After consulting with someone who had used the programme, I began my NUDIST analysis by creating an index system based on seven major nodes. In my mind these constituted possible main chapter areas for my thesis, and they also corresponded with areas of questioning included in the interview guide. From the seven major nodes I developed a ‘tree’ comprising 127 nodes.<sup>12</sup> Developing this index system and coding the interview transcripts took place over several months. It was an intensive process that required a lot of concentration and thus it was difficult to work on more than one transcript in a day. Tesch (1990:155) describes this process as de-contextualising the data, or segmenting the whole into meaning units or analysis units. Because I did not

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<sup>12</sup> See Appendix B for a list of the nodes developed in NUDIST for the purposes of data analysis.

want to ‘miss’ anything, I coded virtually everything in the interviews which, in retrospect, was not entirely necessary. The process of developing the index system involved keeping like categories together and creating new nodes when data did not appear to ‘fit’ into existing nodes. The nature of the data meant that material often ‘fitted’ into multiple nodes, which meant making later decisions about where in the thesis it could be included to greatest effect. Coding data into multiple nodes also facilitated contextualising the data. For example, the interviewee might be talking about the effect of his Catholic upbringing on his concerns about secrecy in DI. In this case, the interview material would be coded to nodes 1312 and 42.

After indexing the data, I produced reports for each node of the ‘tree’ created in NUDIST. Each node report contained the variety of responses to a particular question, or attitudes to a particular aspect of the experience of having a child by DI. Tesch (1990: 122) describes this process of assembling all the data coded to each particular category as ‘re-contextualisation’ because each node deals with one concept, or ‘pool of meanings’. Once the data relating to one particular concept were assembled in one report, they were ready for interpretation. Tesch (1990:114) notes that unlike quantitative analysis, in qualitative data analysis, organisation and interpretation do not take place as two discrete processes; rather they are intellectually intertwined and sometimes happen at the same time. Thus, some of the identification of major themes and sub-themes, and the linking of these to the literature and to sociological theories that might be used to explain them, happened during the processes of transcription, data coding, or re-examining written transcripts.

Nonetheless, most of the interpretation proceeded from examining the interview material once it was reassembled in each node report generated in NUDIST. During this process, I examined each node report for sub-themes within major themes, to get a sense of the variety of participants’ experiences, responses to questions, and the discourses they used to make sense of their lives. Many of the sub-themes that emerged during this interpretive exercise formed the basis of separate sub-titled parts of each chapter. Within each sub-titled section, participants’ talk was organised by grouping together like responses and then arranging them in a sequence to create a coherent whole that presented and analysed a particular aspect of people’s experience.

As part of this process, participants' talk was compared and contrasted with other participants' responses to the same questions to determine similarities and differences. Individual participant's talk was also scrutinised for the use of any conflicting or contradictory discourses, to tease out the complexities, ambiguities and contradictions in people's lives.

According to Lupton (1992:145), discourse analysis has two dimensions: the textual and the contextual. While the textual dimension is concerned with the structure of talk or text (e.g. grammar, syntax, use of rhetorical devices, etc.) the contextual dimension of a discourse analysis links structural descriptions to the social, political and cultural context in which they take place (Lupton, 1992:145). The discourse analysis carried out when interpreting the data for this study focuses on context. It is concerned with making explicit ways in which certain type of talk occurs, and how this links with social interaction and particular situations. In the coding process I therefore took care not to lose the context in which comments were made and discourses drawn on. If, during the process of coding transcript material, I thought the context was unclear, I referred to the participant's whole transcript to 'recontextualise' their comments.

Participants' talk was analysed to determine the way discourse reproduces ideology and hegemony and to establish links between discourse, social interaction and particular situations (Lupton, 1992:145). For example, I paid attention to the words people used when referring to the sperm donor (i.e. was he a 'dad', a 'biological father' a 'real father' or 'the donor'?). As well as attending to the language used, I asked questions about how the meanings attached to these words reproduce general understandings about the nature of 'fatherhood' in a particular social context, and how these meanings inhere in people's attitudes and actions. As Lupton has pointed out, more than a content analysis, which attends to the surface or manifest meanings of texts, a discourse analysis is concerned with the symbolic and latent meanings of texts or verbal communications (Lupton, 1992:147).

## Conclusion

As a researcher and interpreter of the data, I make no claims about the objectivity or universal truth of my interpretations, which are shaped by the particular sociopolitical context in which they were produced (Lupton, 1992:148). However, I have endeavoured to make explicit my own position as a person with particular experiences of 'family' and 'kinship', and as a consumer of fertility services. As a sociologist, I have available to me a range of analytical concepts and theories that are drawn on in my interpretation of the data. The sensitive aspects of this field of research meant that much of what was said had a psychological dimension, on which I was not qualified to comment. Some may wonder how idiosyncratic are the accounts I have presented, but as Pahl (1995:78) has argued, "the reader has to trust me, the research instrument, to be honest and not to create false impressions through sly editing". As previously stated, I make no claims about the generalisability of this material to a particular population. At the same time, I attempt to present a range of people's experiences that are *likely* to be similar to the experiences of others. In some cases, this is supported by evidence from other studies. My interpretations of peoples' talk may be contested but, like Pahl (1995:78), to write about the people I have interviewed for this study I have had to make my own judgements.

## Chapter Three

### Families, Kinship and Assisted Conception

[N]ature and culture have become increasingly isomorphic while remaining distinct. ...nature is being commodified, technologised, re-animated and rebranded in ways that expose its artifice. No longer able to authenticate or pre-exist culture in the predictable ways it once could, nature could be seen to have moved out of the picture in the multiple and intertextual significations of globalising cultures (Franklin, Lury and Stacey, 2000:9,10).

#### **Introduction: a theoretical preamble**

In families with children conceived by donor insemination, notions of human 'relatedness' are complicated by the presence of genetic material received from a (probably unknown) third party. Discussion about changing families, family practices and kinship, provides a useful context for analysis of networks of relatedness in families using donor insemination. The past decade has witnessed renewed academic interest in both the study of families and the study of kinship. According to Smart and Neale (1999:2), the study of families had lost significance for sociologists with the decline of functionalist thought in the 1960s, and the increasing focus of the mainstream sociological 'gaze' on the 'public sphere' rather than the 'private sphere'.<sup>1</sup> In the mid-1990s, 'the family' once again became a focus of sociological theorising. Smart and Neale (1999:4-5) suggest that 'the family' is now being taken up as conceptually and theoretically significant for three main reasons. First, empirical findings have alerted scholars to significant changes in family life and relationships, precipitated by trends such as higher divorce rates, and an increase in 'reconstituted families', which demand further analysis. Second, the changing 'face' of family life has led to heated political debate, with conservative factions pointing to a decline in family values and the demise of 'the family' (Blankenhorn, 1995; Popenoe, 1996), and the corresponding view that these arguments should not go unchallenged (Stacey, 1996; Coontz, 1992). The third reason for renewed interest in 'the family' relates to an increasing focus on 'the family' and intimate relationships by mainstream

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<sup>1</sup> For a more detailed discussion of the marginalisation of the study of family sociology, see Smart and Neale (1999:2-4).

theorists, such as Giddens and Beck,<sup>2</sup> who have indicated that these require analysis if one is to understand changes occurring elsewhere in late modernity.

The new focus on families and intimacy has moved away from the more structuralist view of 'the family' as a static institution among many other social institutions. Contemporary theorists emphasise the diversity of family life rather than the demise of 'the family' (see, for example, Coontz, 1992; Brubaker, 1993; Giddens, 1993; Stacey, 1990, 1996; Silva and Smart 1999; Smart and Neale, 1999). These writers highlight the need to take seriously fluidity and change rather than seeing it as something dangerous and undesirable (Silva and Smart, 1999:2). The use of the term 'the family' as appropriate terminology has been problematised by theorists such as Giddens, who generally avoids the term altogether, preferring instead to focus on intimacy, child-parent relationships, sexuality, and the body (Smart and Neale, 1999:7). Morgan (1996), an important theorist of 'the family', who is more interested in the interiority of family relationships than are the so-called grand theorists of modernity, uses the term 'family practices', which encapsulates the overlap with other social practices and avoids conceptualising the family as a unitary, functional social institution. Instead, Morgan focuses on fluidity, change, gendered practices, adult-child relationships and shifts within intimate relationships and between relationships (Smart and Neale, 1999:22). A strength of Morgan's focus on 'family practices' is that it implies that people are "*doing* family rather than passively residing within a pre-given structure" (Silva and Smart, 1999:5). As Morgan himself points out, he uses the term 'family' in a transformed way, as a constructed quality of human interaction, rather than a "thing-like object of social investigation" (1999:16). He therefore chooses not to abandon the term 'family' altogether, but to think of it as less of a noun and more as an adjective or a verb.

In the 1990s the concept of family has come to signify the subjective meaning of intimate connections, rather than formal, objective ties based purely on biological or marriage ties (Gubrium and Holstein, 1990; Silva and Smart, 1999:7; Stacey, 1999). The work of writers such as Weston (1991) have highlighted that a unitary conceptualisation of 'the family' also implies that everyone participates in the same

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<sup>2</sup> Smart and Neale (1999:6-19) provide an overview of the contribution of these sociological theorists to the study of families and intimacy in late modernity.

sorts of kinship relations which are based on the bonds of marriage and heterosexual reproduction. This, she claims, has positioned gay men and lesbian women as anti-family and “exiles from kinship” (Weston, 1991:22). Weston (1991) argues that, like heterosexuals, gay men and lesbian women can also claim to create families, which include friends and lovers who are actively *chosen*, rather than emerging from a biological connection. In her view, biology is a cultural construct, rather than a self-evident “natural fact” and, as such, is no less a symbol than is choice (Weston, 1991:35).<sup>3</sup> Issues raised by Weston (1991) about the formation of families through choice and love, rather than biogenetic substance, are explored in this thesis, primarily in the context of heterosexual parenting through donor insemination, but also in the context of lesbian parenting through DI.

Weston’s critique of kinship can be linked to other analyses of kinship, notably Schneider’s *A Critique of the Study of Kinship* (1984), which challenged what he claimed were Eurocentric assumptions at the heart of anthropological study.<sup>4</sup> Schneider (1984:197) argued that the axioms that were the foundation of the study of kinship were, in fact, insupportable in the context of all cultures. He argued, therefore, that the only basis on which kinship studies could proceed was to take kinship as an empirical question, not as a universal fact (Schneider, 1984:200). In the light of these comments, in this study kin relations are explored as an empirical question. The thesis explores the meanings people in New Zealand attach to kinship and ‘family’ and whether or not Euro-American conceptions of relatedness, based on the facts of procreation, inform dominant understandings about kin relations in this country.

Schneider’s critique of the study of kinship in anthropology marked a turning point as questions were raised about its place in the discipline. Like the shift of the sociologists’ gaze from ‘the family’, the shift away from kinship in anthropology

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<sup>3</sup> See also Stacey (1999:374) for a discussion of gay and lesbian families as among the diverse family forms that characterise what she describes as “the postmodern family condition”.

<sup>4</sup> According to Schneider (1984:187-188), three axioms underpinned the anthropological study of kinship. First, kinship was one of the four privileged domains, or rubrics, of social science, each of which was perceived as a natural, universal and vital component of society. Second, kinship has to do with the reproduction of human beings, and relations between those who are party to the reproductive process, which is formulated as a sexual and biological process. Third, sexual reproduction creates biological links between persons that have important qualities distinct from the social or cultural attributes which may be attached to them. These biological ties are considered to be ‘natural’ ties inherent in the human condition and distinct from the social or cultural.

marked a general shift in the discipline from structure to practice, and from practice to discourse (Carsten, 2000:2), though each of these exists simultaneously with differing emphases. Renewed interest in the study of kinship in the 1990s can be attributed to feminist work, studies of gay and lesbian kinship, and Strathern's *After Nature* (1992a) (Carsten, 2000:3). Much of the recent anthropological work on kinship in so-called Euro-American cultures has focused on new reproductive technologies, on gender, and on the social construction of science (Carsten, 2000:3). In particular, anthropologists have been concerned with sets of issues about 'nature' and 'biology', and the relationship between the 'biological' and the 'social'. Challenging notions that take for granted a division between the 'biological' and the 'social', Carsten (2000) sets out to show that in many cultures the boundaries between the 'biological' and the 'social' are decidedly blurred and, in some cases, not visible at all. Carsten (2000:4) has chosen to move away from the term 'kinship' and the pre-given analytical distinction between the 'biological' and the 'social' that this implies. Instead, she uses the term 'relatedness' though, this too, she contends, is open to many of the criticisms that might equally apply to 'kinship' (Carsten, 2000:4-5).

The notion of the destabilisation of the analytical opposition between 'biological' and 'social' kinship is central to the conceptual and theoretical basis of this thesis. The thesis provides illustrations of couples and family members both constructing and deconstructing this opposition as they talk about the meaning they give to the use of DI in their families. To analyse this talk, the thesis draws on much of the work of social anthropologists who have written specifically about the cultural implications of new reproductive technologies.<sup>5</sup> The central project of these authors is to 'defamiliarise'<sup>6</sup> the natural basis of human procreation and reproduction (Carsten, 2000:11). Strathern (1992a, 1992b) explores the cultural implications of the use of new reproductive technologies, arguing that in late twentieth century English culture, and Euro-American cultures more generally, what have been deemed 'natural' processes can no longer be taken for granted. She contends that developments in reproductive medicine do not just comprise new procedures but also embody new

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<sup>5</sup> See, for example, Strathern, 1992a, 1992b; Edwards, Franklin, Hirsch, Price and Strathern, 1993, 1999; Ginsburg and Rapp, 1995; Franklin, 1997; Franklin and Ragone, 1998.

<sup>6</sup> This term is used to refer to the ways in which taken for granted assumptions about natural processes, such as conception, are taking place within a woman's body, beyond the gaze or intervention of humans.



knowledge (Strathern, 1995:347). Through the use of procreative technologies dispersed kinship is constituted in dispersed conception: it includes those who “produce” the child with assistance as well as those who assist (Strathern, 1995:353). Thus, she maintains, there exists a group of procreators whose relationship to one another and to the child is contained in the act of conception itself and not in the family as such. Thus, in her view, while Euro-American kinship thinking may be predicated on the “facts of life”, learning more about the facts of life will not, these days, necessarily tell us more about kinship (Strathern, 1995:359-360).

Like Strathern, Franklin (1995, 1997) contends that the hitherto unavailable choices extended to consumers by the new reproductive technologies, which are often constituted as ‘giving nature a helping hand’, have resulted in a destabilisation of nature. Franklin (1995:333) asserts that while stories about “the birds and the bees” referred to a ‘natural’ unfolding process,

the new narrative of assisted or achieved conception tells a different story. This world becomes visible and knowable through technological means, creating new forms of accessibility to and improvement of reproduction. The necessity for technological assistance thus comes to be seen as a product of nature itself. In this slippage, whereby the “helping hand” of technology is both conflated with, and yet also displaces, nature, a key shift in the cultural meaning and organisation of reproduction must be seen to lie (Franklin, 1995:333-334).

In this view, technology can no longer be construed as “interfering with nature”; rather it assists ‘natural’ events such as conception and therefore can be conceptualised as standing in for ‘nature’. Nature and technology thus become mutually substitutable. While destabilised nature can appear to be less credible, Stacey (2000) argues that denaturalisations are quickly transformed into renaturalisations, and decontextualisations into recontextualisations. Thus, the commodification or instrumentalisation of nature “presents little threat to its continuing pervasiveness as authenticator” (Stacey, 2000:140).

New ways of thinking about kinship, made possible through the new narrative of achieved conception, challenge modernist distinctions between the artificial and the natural, the biological and the social, and between nature and culture. While much of Strathern’s work highlights the centrality of pre-given biological facts to Western

understandings of kinship, writers such as Haraway (1991) have investigated the cultural construction of a scientific realm of ‘natural facts’. Through her work on primatology, Haraway (1991) has shown that the boundaries between nature and culture are much more *permeable* than biological or social scientists might assume. Haraway (1991) questions the existence of ‘biological facts’ in a separate realm from culture. Instead, she argues that ‘scientific facts’, supposedly awaiting discovery in the ‘natural world’ are, in fact, actively constructed by scientists located in particular historical and social worlds. The notion that ‘natural facts’ are constructed and not discovered is radical, according to Carsten (2000:11), because it goes against dominant Western assumptions about the ‘natural world’.

Haraway (1991:8) maintains that we have accepted at face value the so-called “liberal ideology” of social scientists in the twentieth century that maintains a deep and necessary split between nature and culture. Such ideologies, she argues, have legitimated beliefs in the natural necessity of aggression, competition and hierarchy (Haraway, 1991:22). She also points out that, while feminists have successfully deconstructed the nature/culture dichotomy, they have been less successful in challenging the sex/gender dichotomy. This, in turn, has meant they have been less powerful in deconstructing how bodies appear as objects of knowledge and sites of intervention in ‘biology’ (Haraway, 1991:134).

The ‘destabilisation’ of nature and the disruption of the binaries of nature/culture and biological/social offer new ways of thinking about kinship and, more broadly, ‘relatedness’ between human beings (Carsten, 2000:24). Some of the studies appearing in Carsten’s volume point to an analysis of kinship that is more dynamic and creative than one based on a simple division between the ‘social’ and the ‘biological’. For example, Carsten refers to anthropological studies that point to a combination of sentiment, substance, and nurturance as grounds for relatedness (2000:22). This links to some of the concerns of my thesis in relation to the significance couples who have conceived by DI give to the substance of donated sperm, and how this connects to other ways they conceptualise relatedness. Edwards and Strathern examine the multitude of possibilities the biological/social divide presents for the inclusion and exclusion of persons (2000:162). What these authors are particularly interested in is not so much what is considered to be ‘social’ or

‘biological’, but what happens at their intersection (Edwards and Strathern, 2000:150). They argue that a distinguishing feature of twentieth century notions of kinship in Euro-American cultures is the division *and* combination of social and biological facts.<sup>7</sup>

Drawing on recent theorising on families, kinship, and ‘relatedness’, this chapter examines the ways in which people in families with children conceived by DI talk about biological/genetic and social relationships within their family and extended kin group. The chapter draws on social anthropological theory about kinship to highlight the social construction of ‘biological’ and ‘social’ parenthood. It also examines how conceptualisations of the ‘biological’ and the ‘social’ and ‘nature’ and ‘nurture’ may be both distinguished and combined. The talk of those interviewed highlights the permeability of concepts that have often been positioned as diametrically opposed. The first section of this chapter looks at how those who have children through forms of assisted conception simultaneously utilise, disrupt and transform cultural assumptions about the ‘natural facts’ of life. Their talk illustrates Strathern’s (1992b:15) argument that the procreative choices that new reproductive technologies afford will affect thinking about kinship, and other ideas about relatedness between human beings. This section also pays attention to the concepts of the ‘blood ties’ and ‘the natural’ and how these are socially produced. The second section looks at the nature/nurture dichotomy and the way parents and family members of children conceived by donor insemination use and challenge this opposition when considering the contribution of hereditary and environmental factors in the creation and development of their child. Issues raised in this chapter about biology and ‘nurture’ are also considered in later chapters, for example, in connection with the significance attached by some people to family resemblance, and the ways in which the donor is conceptualised.<sup>8</sup>

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<sup>7</sup> The authors argue that the nature-society combination/divide is central to the work of actor-network theorists such as Latour.

<sup>8</sup> See Chapter Eleven for a discussion on the significance of physical relatedness in the form of family resemblance, as a way of constructing and conceptualising human relatedness. Barnard (1994:787-8) argues that there are three possible levels of analysis in connection with physical relationships: true genetic relationships between individuals, ‘biological’ relationships (as defined by people of the society in question) and social relationships. The middle category refers to socially constructed ‘biological’ knowledge, which is not universal but culturally specific. According to Barnard (1994), physical resemblance falls into this category because it may or may not be based on a genetic relationship between individuals.

### **Kinship, family and the social construction of ‘natural facts’**

Strathern (1992a:45) acknowledges the way anthropologists have distinguished ‘nature’ and ‘culture’, but stresses that the axioms that Schneider (1984) critiques are nonetheless the basis of kinship’s identity in the discipline. For Euro-Americans, at least, both Strathern (1993) and Schneider (1968 [1980]) suggest, kinship is a context in which people talk about relationships based on biology. Strathern argues:

Whether or not the relationships are consequently activated, for Euro-Americans there is no getting around the tie that exists with those persons whose genetic substances combined at the child’s conception. This is taken as a fact of life (Strathern, 1993:14).

Strathern therefore maintains that biological connections between persons, formed through the act of procreation, are the cornerstone of Euro-American thinking about kinship. According to Strathern (1993:17), to talk about kinship in Euro-American culture is to refer to the way in which social arrangements are based on natural processes. This overlapping of the concepts of the social and the natural supports prevailing orthodoxy in many social science disciplines that the subjects of study are ‘social constructions’. In the case of kinship, Strathern maintains, what is at issue is the social construction of ‘natural facts’, which themselves are revealed to be social constructions (1992b:17). Strathern argues that ideas about kinship and the formation of families are overlaid with notions about the natural “facts of life” (Strathern, 1992b:3). These natural facts of life, she says, are thought of in broad terms as ‘biological’ and, more narrowly, as ‘genetic’.

The idea of a genetic parent, for instance, brings together what is known about human heredity and the fact that a relationship is entailed, because, for Euro-Americans it is virtually impossible to talk of a parent in a human context without evoking the idea of potential social relations (Strathern, 1992b:3).

In a culture where biological ties and parenthood are inextricably linked, the genetic parent is assumed to be the ‘real’ parent (Strathern, 1992b:16). The man who raises the child, who has had a relationship with the child, arguably from conception, is qualified as the ‘social’ father, or he has some other label such as foster-father, step-father, or adoptive father (and the same applies to mothers). In a sense, he is secondary to the ‘real’ or ‘genetic’ father. Disrupting this notion, my research shows, however, that a number of discourses about connectedness exist that draw simultaneously on the power of ‘blood ties’, as in the notion that “Blood is Thicker

than Water,” and the power of social connection. Illustrating this point, Richard and Belinda, parents of a daughter, Madison, conceived by DI, were distressed when a friend asked if their daughter resembled her ‘real’ father (meaning the donor). They said:

Richard:           And, what did she say? She said, “Gosh she looks like...”

Belinda:           No, she said, "Does Madison look like her real father?" and I said, "Of course she does. She's got a double crown, so her hair sticks up a bit like Richard's." And she said, "No, no, her *real* father. Haven't you got photos of this donor?" ... And I just said, "Angela, Richard is her real father." And I just left it at that. I was so annoyed.

This example illustrates Ragone’s contention that individuals who participate in collaborative reproduction “routinely manipulate categories of meaning as they pertain to issues of relatedness” (2000:70). Belinda uses resemblance to make connections, specifically physical connections between Madison and her father. Physical resemblance is used as a way of invoking relatedness even where there is no genetic tie (Ragone, 2000:67). This illustrates Barnard’s (1994:786) contention that “[e]ven in Western societies, ‘biological’ kinship is often as much a metaphor for social relations as a statement of relevant biological fact”. Belinda recognises the discourse that prioritises physical connection, she utilises it and, at the same time, she resists the notion that a ‘real’ parent is the biological/genetic or donor parent. In this way, Belinda can be perceived as reworking the nature/culture dichotomy as a strategy to identify her husband as the sole father of their child (Ragone, 1996:360).

Strathern (1992) suggests that Euro-Americans privilege ‘blood’ ties over social connections/linkages. She asserts that “the concept of a blood ‘tie’ symbolises the further fact that relatives are seen to have a claim on one another by virtue of their physiological makeup” (1992b:18). Sarah and Tim, the parents of children from a variety of biological and social origins,<sup>9</sup> said that their family members and friends were concerned about the potential for interference in their lives from people who had a biological claim to their children. These included their adopted children’s birth parents and, potentially, their sperm donor. Sarah commented as follows:

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<sup>9</sup> Rob their first child was adopted (a ‘stranger’ adoption); their second child Phoebe was adopted from within Sarah’s family (Sarah’s sister gave birth to Phoebe two months before Charlotte’s birth); and Charlotte, their third child, was conceived by donor insemination. Recently they took on a foster daughter, Amy, a friend’s child, who is older than their other three children.

Sarah: Well, they get a bit worried, all the family get a bit worried about us getting stretched, you know. Like, I was talking about the other day, we had Rob's birth family, and then Amy's family, and that's actually something aside, and what's going to happen if Charlotte's donor ever wants to meet her? And they kind of feel worried, but they are worrying unnecessarily in the future, because you know...

KH: It's just possibilities that might not happen?

Sarah: But people are scared of the unknown. You know, they have a fear of it and Tim and I don't have that fear. We just get on board when it happens.

Sarah revealed that her family members, who have a 'social' claim to her children, were threatened by the risk of a prior claim by the children's biological relatives (Rockel and Ryburn, 1988:147). She claimed that family members and friends expected that she would feel 'closer' to the child that she had borne herself than to her adopted children and foster daughter. Sarah disputed this. At the same time both she and her husband Tim acknowledged that having a child that was biologically related to them both had been their "first choice". Sarah retained a "wee hope" that she will conceive with Tim, but was concerned about the effect that having a child biologically related to them both would have on their other children, who were not genetically connected to both parents. She commented:

Sarah: Actually, we're quite worried if we do have a child naturally, because all this bullshit from friends and family – "Oh, you've finally got one of your own" – and they'll all be watching me to see whether I interact with it the same. And people say to me already, oh, you know, "Do you feel closer to Charlotte, because you've had her, than the others?"

The assumption reportedly expressed by her family members and friends was that biological ties between parent and child are somehow intrinsically 'closer' than social ties, or that biological ties foster closer social ties. This relates to the idea that unless a relationship is grounded in some intrinsic or natural connection, then Euro-Americans are likely to think of it as 'artificial', and to be thought artificial is to be open to uncertainty: reality lies elsewhere (Strathern, 1992b:27). Most social relationships, including relationships between parents, however, do not have 'biology' as their basis. So this is understood as something particular to certain 'family' or kin relations, such as between parents and children, or between siblings. Moreover, in Euro-American kinship ideology the child represents the symbolic fusion or unity of the couple (Ragone, 2000:70). The language and the understandings that construct the specialness of these 'connections of blood' exist side-by-side with other significant social relations not constituted in this way. In *Families We Choose*, for example, Weston (1991) critiques the notion of the centrality of biological ties as the primary

basis of kinship. She contends that kinship in lesbian and gay families is founded on the basis of choice and love, rather than a shared biogenetic connection. Weston argues that, while some have located gay men and lesbians beyond the bounds of kinship, and labelled them as “anti-family”, gay men and lesbians form their own distinctive family type, which is the product of choice and biology (1991:40).<sup>10</sup>

The idea that biological/genetic connections are somehow ‘closer’ than social ties is also played out in the public discourse that men are more likely to bond with a child to whom they are genetically related. One mother of a child conceived by DI said that women in her antenatal group (whom she had not told about her child’s DI origins) commented that a genetic tie was necessary for a man to bond with his child. Some fathers included in this study had had initial concerns about how they would relate to a child who was not genetically related to them. Peter, the father of a daughter conceived by DI, observed:

Peter: It hasn't really been [an issue]. It's quite surprised me actually, ah, it was probably more difficult when Erica was a baby because I didn't relate so well to Erica as a baby. But now that she's been a toddler, and you know, she's a little girl now. It's never really... it's actually become less and less of a factor.

Peter’s perception of the lack of genetic tie between himself and Erica reveals an interesting tension. He is saying that it was *never* an issue, but he also acknowledges that it *was* an issue, but has become less and less important as the social bond has been established. This social bonding has to occur between all parents and their offspring. But the significance given to biological connection means that emotional bonds are assumed, and therefore perhaps facilitated. Peter appeared to feel more ‘secure’ in his connection with Erica after the social bonds were formed, but many men might have difficulty relating to a baby. Alice, Peter’s partner, appeared to believe that the strength of the social bond between Peter and their daughter, that would continue to develop over time, would ensure the child’s genetic tie to the donor was insignificant in comparison.

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<sup>10</sup> In Weston’s view, “families we choose” incorporates the lovers, former lovers and friends that gay men and women choose to count as ‘family’. The inclusion of a biological factor in this concept of family does not invoke the biological connection between parent and child, but instead the belief upheld by many gay men and lesbians that they do not simply ‘choose’ to be homosexual. Rather, they have some predisposition to respond erotically to those of the same gender, and that the ‘choice’ to be gay was therefore an outcome of this self-awareness. Thus, Weston’s argument points to a different

Alice: I think she's going to grow up fairly firmly knowing that Peter is her...'social' father sounds like it's so inconsequential, it's not the right term...but her father in kind of all other senses. I mean, they have a very good relationship now. Um. So she's going to grow up quite secure in that, but she knows there's this other person off to the side who helped us...

Alice privileges social ties over biological/genetic ties: the donor, or the biological/genetic father of the child is relegated to a position “off to the side” and marginal to the core relationships between Erica and her parents. This relates to conceptualisations of technologies used in assisted human reproduction as merely lending a “helping hand” in the process of conception, enabling an infertile couple to have a child of *their own*.<sup>11</sup> In Alice’s view, the ‘social’ father takes precedence as the father “in all senses”, other than having provided the genetic material for his child’s conception. Alice’s comment on the inadequacy of the term ‘social father’ challenges social/cultural understandings that privilege biological over social ties, and that position the social role secondary to the biological/genetic role. Furthermore, her comments about the significance of the relationship between Peter and Erica are consistent with Ragone’s discussion about the way the intention to conceive a child is seen as a decisive factor in determining parenthood. For example, in court cases relating to gestational surrogacy in the United States, when the surrogate mother had decided to keep the baby, the court had found in favour of the commissioning parents. This was not because of their genetic tie to the child, but because it was their *intention* to become parents that had led to the conception and birth of the child (Ragone, 2000:61).

Alice relates her perception of the significance of biological ties to her own experience of having a father who was adopted. She claimed that her father discovered “by accident” that he was adopted when he was 21 years old, but he had never “bothered” to trace his birth family. After his death, Alice had found out some details about her father’s birth mother’s family, and had thought about tracing her “for curiosity’s sake”. She appeared to be interested in finding out her father’s genetic/biological background because of a sense that something was missing by not knowing anything about her father’s predecessors.

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notion of biology from the concept of biological ties created through human reproduction (Hayden, 1995:45).

<sup>11</sup> As discussed earlier in this chapter (Franklin, 1995:333-334) refers to the ‘slippage’ that occurs whereby the “helping hand” of technology is both conflated with, and displaces, nature.



Alice: ...it always felt like Dad's side stopped with Dad, because he was adopted and, you know, in that kind of sense he was...it felt like there wasn't much point taking that family tree back any further.

Although she claimed to be curious about her father's birth family, Alice distinguished between the meaning attached to her father's relationship to his birth mother and the meaning attached to the relationship between a child conceived by DI and the anonymous gamete donor.

Alice: There is a difference between a donor father and someone who's had a relationship with the mother. And there's a different kind of meaning of that, but I think there's still... from the child's point of view, there's still that need to put a few jigsaw pieces sort of in the right place...I don't know...or there might be.

Alice acknowledges that biological ties have significance for human affairs (Strathern, 1992b:18), but that the degree of significance and the way this might be played out in individual people's lives is variable. In relation to her young daughter's life, its significance is as yet unknown. As she considers these issues, Alice draws on 'adoption' discourse that constitutes adoptive parents as the *real* parents and 'natural' fathers and 'birth' mothers as 'inferior', lesser parents. At the same time, she draws on a children's rights discourse of 'the right to know' about biological ancestry (Rockel and Ryburn, 1988:59-60; MCART, 1994:32-33; New Zealand Law Commission, 2000:67).<sup>12</sup>

As Alice pointed out, the concept of biological/genetic ties can be explored through the idiom of genealogy or family trees. When asked about their interest in or knowledge of their family tree, some research participants reported that they had become interested in their family lineage after becoming a parent through DI. Neil, who himself was adopted, decided to trace his birth parents when he became a father. In response to a question relating to the significance for him of biological ties and knowing his ancestry, Neil replied:

Neil: It wasn't and isn't that important to me. It was really just the combination of nothing in the future and nothing in the past. And also, thinking that at some stage, my...our children may wish to find out for themselves their genetic origin, and that I felt having...if I went through the process myself, then I'd be in a better position to understand the sorts of issues that might

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<sup>12</sup> In New Zealand, the Adult Adoption Information Act 1985 gives adult adopted people and birth parents access to information about one another, while providing safeguards for those who want privacy (Rockel and Ryburn, 1988:59-60).

come up for them. So, it's very hard for me to say, for myself, ah, what specifically, apart from that, was important.

Neil's talk about the meaning of biological ties reveals a dual direction. He wants to know his biological origins for his children's sake, but also because they are not his genetic children. It reveals that his 'biological' links are only backwards in time. Although he and his family now have on-going contact with his birth mother, Neil clearly thinks of himself as part of his adoptive family, the Moores, rather than as a member of his birth family. He therefore had adopted the Moore's ancestry as his own, though it is less clear whether he expected his children to do so because, from a young age, they had developed a relationship with his birth mother, their other grandmother. Neil and his wife Patricia commented on his 'lineage':

Neil: I've got one little booklet which is entitled "How the Moores came to New Zealand" and I've got another little collection of background information about my birth mother's family. I relate more to the story of how the Moores came to New Zealand, but there's no genetic lineage there.

KH: So your children could also 'adopt' the Moores as their ancestors?

Neil: Mm. Well, of course we have regular contact with my birth mother. There are some presents there [under the Christmas tree] from Nana.

KH: So they call her Nana?

Neil: Yes. I never call her Mum.

KH: Do you call her by her Christian name?

Neil: Yes. There's certainly a clear distinction for me.

Patricia: I think that they're [Neil's biological parents] just the...I suppose, a key, if you like; that Neil grew up with Mum Moore and the bond is there. What Neil is saying is that the connection he has is closer with the Moore lineage because that's where the bond is; that maybe the bloodline doesn't necessarily have to be so important because really the importance is in that bond within the family that's developed.

Neil's birth mother now has a *social* persona: she is not just interesting as a genetic connection. She can be the children's nana, but not Neil's mum. This scenario illustrates the fluidity of families and the possibility of having several mothers, fathers, and grandparents by different routes (Smart and Neale, 1999; Silva and Smart, 1999).<sup>13</sup>

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<sup>13</sup> Adding to the complexity of their family connections, in more recent years Neil and Patricia's eldest daughter has 'added' to her 'family' by forming a relationship with a genetic half-sister: a girl in another family with the same genetic father. This was facilitated by the Donor Family Register, a voluntary register of families with children conceived by DI, which is discussed in more detail in Chapter Five.

Other families with children conceived by DI also contended that bloodlines were less significant than social relationships. Joe, the father of three sons conceived by DI, expressed little interest in his own family tree. In relation to it, he said:

Joe: Oh, I'll leave that to somebody else to sort out. The thing is that I'm first generation New Zealander, so to trace my genealogy back would be a right pain.

Ella: Yes, Mum's got a family tree hasn't she?

Joe: Yeah, we've got one on my mother's side. I may have seen it once or twice - doesn't rate high with me.

Joe and his wife Ella told of his father's delight when their first son conceived by DI, and his father's first grandson, William, was born.

Joe: William was the prize.

Ella: He was their first son.

Joe: Grandson. He'd had four granddaughters before that.

Ella: So whether he had Joe's blood or not. It didn't matter. He was special.

Joe: He carried the name on.

Ella: Yeah (laughs).

Joe: It meant a lot to my father. I don't know why.

Ella: William was always special to Dad because he was the first grandson.

Joe: I think what it was as much that he was the first boy.

Ella: Yeah, I thought that it might make a difference that he wasn't the same blood, you know.

Joe: It didn't.

Joe and Ella revealed that, although their son was not tied 'by blood' to his grandfather, his birth symbolised the continuance of the family name. This supports Hayden's argument that biology is an important symbol of relatedness that can be articulated and embodied in many ways, including through naming practices (1995:50). Joe theorised that his father's perception of the significance of blood ties embodied in the sharing of biogenetic substance was embedded in his own experience of family life. His father was orphaned (and perhaps brought up by people who were not his biological kin) and so it is possible that he valued social relationships rather than genetic connections. At the same time, however, his apparent pleasure in the

arrival of a grandson who continued the family name invokes the figurative sharing of a biological connection.

Particular experiences of ‘family’ were therefore important in determining the ways in which people drew on discourses that divided and/or combined notions of biological or social ties in defining kin relations. Kathy’s eldest daughter, Melissa, was conceived by DI, and her younger daughter Nicole was conceived without assistance after fifteen years of marriage. She appeared particularly conscious that others might perceive her daughters as ‘half-siblings’, a term she studiously sought to avoid because it implied that her daughters’ relationship was somehow ‘less than’ it would be if they were ‘full’ siblings. She linked her views on this to her own family background.

Kathy: [My mother] probably doesn’t treat Melissa any differently [from Nicole], but she comes from a step-parenting situation herself in her own family. Her mother remarried. And I guess that’s my issue: she’s always heightened her half-brothers and sisters, by saying ‘my half-sister’. She doesn’t refer to Lily as her sister. And I’ve always...even before I had children...disliked that. I thought, family is family.

Kathy was uncomfortable with her mother’s insistence on referring to her ‘half’ siblings. She did not enjoy close ties with her biological relatives, and claimed that her family of origin was ‘dysfunctional’ despite the assumed bond created by biological ties:

Kathy: At 14 I’d gone to live with other people...a young man at the time that I actually went out with...with his family. I remember thinking, “this is actually a proper family”. It was the first time I’d actually realised a proper family.

KH: So you didn’t feel yours was?

Kathy: Oh, it was totally dysfunctional, an absolutely awful family, terrible.

KH: And your parents?

Kathy: Didn’t see eye-to-eye. ...They stayed together for the sake of the children (she laughs). No, it was awful. It was just a totally dysfunctional family. It was Mother who actually threw me out at 14. We were sort of pretty angry kids anyway. I mean, we’d been put into kids’ homes over the years when she needed a break, and shunted and shovelled, so yeah.

For Kathy, a ‘proper’ family was defined socially, not in terms of biological connectedness. Other participants commented that biological ties did not necessarily lead to close family relationships. Jane, the mother of twins conceived by DI, said:

Jane: ...you can have families that can be quite disjointed as well, even if you've got the blood ties. I know my family is completely disjointed really, because of Mum being sick a lot, and you know how families [she makes the sound of something being torn apart] because of stigmas...my mother was sick a lot...with having breakdowns and there was a stigma with that...Yeah, our family pulled apart really. My father tried to keep it together, but I think that's really...so the point about the blood thing is, you might have relations that are tied by blood, but they mightn't be close.

According to Jane, the social stigma of her mother's illness had somehow discredited her family, 'spoiling' its identity and by inference that of its members (see Goffman, 1963) to the extent that it affected the quality of their social relationships.

Other parents, because of their somewhat negative experience of 'family', showed little desire to reproduce their family's genes. Sean, a father of a young daughter conceived by DI, commented that he did not care to carry on his family genes because he did not particularly like his blood relatives. In this way, DI can be constructed as having a 'silver lining' in that one can avoid perpetuating 'unfavourable' genes. This was revealed when I asked:

KH: Did you think of it being a problem having a child genetically related to one of you and not the other?

Pippa: Yes, well that was quite easy because Sean's not got much family, or we don't see them...

Sean: (He laughs). More to the point, I don't like the ones that I've got! So I'm not particularly keen to preserve the Clark genes.

Pippa: No. We were both upset initially, and I think I was quite...I really wanted a little Sean or whatever, but then I kind of moved on from that, and it wasn't such an issue for Sean, like a lot of guys, once he'd got through the mourning stage.

Sean and Pippa raise the issue that the significance of the biological connection lies in the social connection, or relationship, between the couple who seek to parent or have a child *together*. The conception of a child is an expression of the love and commitment of two people to each other, rather than necessarily a desire to perpetuate particular genes or bloodlines. More than just to each other, it is a commitment to a joint set of actions and responsibilities that inhere in parenting as a practice.

Many participants appeared to question the significance of biological ties by suggesting that what was more important was that couples were able to have children, no matter how that was achieved. Strathern argues that procreation can now be

thought about as an act of preference or choice: the child itself becomes the embodiment of the act of choice (1992b:34). According to Strathern, “we live in a world where we think that a child ought to exist by choice. This idea of choice is already embedded in a matrix of other analogies – this matrix is the Enterprise Culture” (1992b:35). The point of political concern here, Strathern asserts, is the hidden prescription that we *ought* to act by choice: in contemporary Euro-American culture in a sense there is no choice *not* to consume (1992b:37-38). In the same way, in the context of assisted human reproduction, parenthood is constructed as the intentional or deliberate choice to conceive and bear a child, as opposed to this possibly happening unintentionally (Ragone, 2000:61).

Tim and Sarah wanted to be parents, but were unable to conceive by themselves because of male infertility. So they exercised choice in order to achieve their goal of having a large family, albeit not in the way they had originally planned. Nevertheless, having adopted a child, exercising choice by using conceptive technologies that enabled them to have a child by DI was a source of anxiety for Tim. He expressed his original concerns about having a family comprising children of ‘mixed parentage’.

Tim: When we discussed having a donor child, I said it would be nice but it was still hard, and then, um, because I thought, we'd already adopted one, you know, and going for a donor child as well... I just sort of thought there may be problems not too far down the line, which is ridiculous really, when you look at it now, but at the time, I thought, oh no, we've got an adopted child, a donor child, then have one of your own, and you've got all these little mixed little children and you're going to have a mixed up family, you know. Starting off mixed up. All these things are going to come out when they're teenagers and you know, we were looking too far ahead basically.

Tim invokes a discourse about the significance of biological connection in families through shared biogenetic substance. At the same time, having experienced being a father to children of mixed ‘origins’, he suggested that his fears might have been groundless. Adding to the spectre of a ‘mixed up’ family, Sarah wanted to donate her eggs to an infertile couple, but said that Tim would not support her in this.

Sarah: Tim would not go along with me. He'd still be supportive, but he's got a question mark over it all now. And the other thing is, this mixed bag, you know: stranger adoption, family adoption, donor child, foster child, egg donor child somewhere out there, and then we'll have our own. You know, he has got this fear of the whole bloody thing coming back and hitting me with a vengeance.

Sarah took some consolation in the fact that in contemporary New Zealand society it has become almost commonplace for children not to be living with both their biological parents, primarily because of divorce and reconstituted families. She thus drew on a discourse about fluidity, change and potential fragmentation in the context of family relations (Smart and Neale, 1999). She said:

Sarah: Well, another thing that happened way back in the beginning that helped us with our decision with the kids all coming from different directions was, just a friend was...I was talking it over with a friend, she said "Look Sarah, walk into a primary school today, of seven year olds, and ask the children who live with their biological mother and father to put their hands up," and she says "less than a third of children these days live with both their biological mother and father." There's step-parents, and step-brothers and half-brothers and half-sisters and... and it's actually a whole society thing. Our children, we hope, are going to be ahead of the 8-ball because they have come together from different backgrounds because of love. They're not where they are because of non-love. And so, although that was a real simple thing that she said, it was a really pertinent thing for the way our family came together, or I found it was.

And I tell you, once you get the baby, all those other fears that your friends and family ...it just goes out the window, eh. A baby is a baby. And it's just that people that can't have children naturally, we've just got to deal with so much more shit than everybody else has to.

Like Weston's (1991) gay and lesbian families, Sarah posited a model of family that is formed through active choice rather than biological ties. To her, exercising this choice meant that they had children who had become part of their family because of their well-considered desire to become parents, and to care for their children. Sarah's comments link to notions about change and diversity in family forms in late twentieth and early twenty-first century Western societies, where no rigid definition of the 'proper' family exists, and new normative guidelines are emerging (Silva and Smart: 1999:4). It also links to the new focus on 'family practices' which, embracing fluidity and change, focuses on gendered practices and adult-child relationships, rather than 'the family' as a static, isolated institution (Morgan, 1996; Smart and Neale, 1999:22; Silva and Smart, 1999:5).

Like Sarah, who found that family members expressed concerns about the mixed biological/genetic origins of their children, Joanna, the separated mother of two DI children conceived by different donors, said that her mother had expressed similar concerns:

Joanna: I don't think she was thinking when she was talking, because I've been with [her new partner] for about four months and Mum was saying...I don't think she was thinking...she was saying, 'Oh next thing you'll probably get pregnant or something.' And I said, 'Oh well, that's not so bad,' and she said, 'You'll have all these half-brothers and sisters running around then won't

you?’ and I said, ‘Pardon?’ I don’t think she sort of clicked what she’d said, but she’s never said anything like that before.

Joanna raised the issue of the ‘step’ phenomenon, which is widely constructed as a source of tension in some families. While the number of step-families may appear to have grown amidst rising divorce and re-marriage rates (Smart and Neale, 1999:4; Silva and Smart, 1999:9-10; Fleming, 1999), the theme of the tensions that can exist between half-brothers and half-sisters is as ancient as the fairytale Cinderella.

### **Nature vs Nurture**

Debates in the scientific literature about the relative importance of heredity and environment were variously used by parents in the study to make sense of the origins of some of their children’s characteristics. The nature/nurture debate itself has its origins in the work of Sir Francis Galton who, at the end of the 19<sup>th</sup> century, postulated that hereditary influences rather than environmental factors account for why some individuals succeed in life while others fail (Paul, 1998:81). Paul claims that this view was somewhat controversial at the time, and that the debate between “hereditarians” and “environmentalists” has become more sophisticated over time. What is most remarkable about it, she contends, is that it is a debate that “refuses to die” (Paul, 1998:81). At times, pronouncements have suggested that the debate is over. For example, a former editor of *Science*, Koshland, indicated that evidence supported an interactionist view: “sensible people” would reject the hereditarian view that genes determine everything, and the environmentalist view, that they determine nothing (Paul, 1998:82). The debate, according to Paul, has nonetheless continued in various forms influenced by events such as the Cyril Burt scandal<sup>14</sup> of the 1970s, and the development of arguments supporting the environmentalist position.<sup>15</sup> At the same time, Paul argues, even those who were most critical of the view that intelligence was determined by heredity, took for granted that the differences *within* populations were to some degree heritable. Subsequently, according to Wright (1995:48, original emphasis), the debate was transformed into a “statistical war over

<sup>14</sup> According to Paul (1998:37-39), Cyril Burt had carried out research on groups of identical twins that found that the IQ scores of identical twins were always closely matched whether they were raised together or apart. His results were later found to be fraudulent and his work discredited. Surprisingly, Paul maintains, authors of genetic textbooks nonetheless continue to cite his results.

<sup>15</sup> For example, the work of Jensen and Herrnstein indicates that social class might account for some differences in IQ between populations (Paul, 1998:85).



percentages – *how much* of our personality or behaviour or intelligence or susceptibility to disease is attributable to our genes, as compared with such environmental factors as the family we grow up in...”.

As Paul argues, debates framed in terms of the relative importance of social and genetic factors are very difficult to resolve. Some authors have argued that environment and heredity are too closely entwined to enable a separation and accurate measurement of any genetic contribution (Paul, 1998:86). Further complicating the issue of whether genetic makeup can ever be separated from its environment, Strathern cites the work of Johnson, an embryologist (1992b:122-123). According to Strathern, Johnson has demonstrated that “personal identity is the outcome not just of unique genetic combination, but of a unique history of continuous development which affects the way that genetic factors themselves take effect” (1992b:122). In this way, the individual is always in interaction with the environment. But, she adds, Johnson is suggesting more than this by emphasising that *everything* beyond the person potentially may influence what this person becomes (Strathern, 1992b:123). The problem of ‘measurability’, however, remains. But, as Paul points out, that the nature/nuture debate continues is less a matter of good science versus bad science: it is highly politically charged (1998:91).

Critics of binary logics such as nature/nurture, mind/body and sex/gender claim that the maintenance of these dualisms has served particular political ends (Gatens, 1996; Haraway, 1991). Gatens argues that theorists who uncritically assert that the human subject is predominantly determined by heredity or environment posit a naïve causal relationship between the body and the mind, the environment and the mind, or the environment and the body, which implies a neutral and passive conception of the subject (1996:8). She suggests that if we think of the body as neutral and passive, and consciousness to be socially determined, then we are suggesting a behavioural conception of subjectivity. But it remains unclear, she argues, as to whether a behaviourist conception of conditioning has any validity when applied to humans. Freud, she contends, stressed that perception was an active rather than a passive process (Gatens, 1996:8).

According to Haraway (1991:8), the liberal ideology of social scientists in the 20<sup>th</sup> century has supported the maintenance of a deep and necessary split between nature and culture. Haraway examines theories of production and reproduction which, she maintains, rest on the liberal doctrine of the autonomy of nature and culture (1991:42). Although, she argues, these theories do not condone a position of biological reductionism, they nonetheless present a picture of human universals, and of human nature as the foundation for culture (Haraway, 1991:42). Second wave feminists, according to Haraway, criticised the binary logics of the nature/culture pair, but this did not extend to the derivative sex/gender distinction, because maintaining this divide was politically useful in combating biological determinist arguments constantly used against feminists (1991:134). Because of this, sex and nature remained passive categories and formulations of an essential identity as man or woman was left untouched and politically dangerous. This has led to a conception that nature is *simply there*, and the categorical and over-determined aspect of 'nature' as an oppositional ideological source is overlooked (Haraway, 1991:134). The on-going tactical usefulness of the sex/gender distinction has led to "dire consequences for much feminist theory, tying it to a liberal and functionalist paradigm" (Haraway, 1991:136). The task, Haraway suggests, is to 'disqualify' the analytic categories like sex or nature that lead to univocity (1991:135). Towards this end, she cites Butler's contention that the "concept of a coherent inner self, achieved (cultural) or innate (biological), is a regulatory fiction that is unnecessary – indeed inhibitory – for feminist projects of producing and affirming complex agency and responsibility" (Haraway, 1991:135).

In this study, a scientist in one of the fertility clinics commented that while the pendulum appeared to swing in relation to the nature/nurture debate, there would always be attention to both. She suggested that one influence might appear more evident at one time than another in relation to particular persons. Nature and nurture were conceptualised as two entities that could be differentiated and/or combined. Our conversation about the importance of heredity and environment proceeded as follows:

KH: Thinking about these issues about how important it is to actually know your genetic history, or your family history, a lot of people I talk to, recipient couples are more inclined to say their child is their child, and they have a loving relationship.

Scientist: And they've got a complete satisfying family.

KH: But there's always this notion about the importance of having some notion of one's heritage.

Scientist: And perhaps that may become more important as these children grow up themselves and are having children, and the whole sort of genetic linkage perhaps becomes more significant. I was going to say, this woman from the States that I knew, it was quite interesting, her parents had actually divorced at some stage; after she grew up I think. But she still had a really close relationship with her father. If anything she was closer to her father than her mother. In spite of the fact that he wasn't her biological father, and he was no longer married to her biological mother, the social father was very important to her.

KH: But it's just a missing gap in terms of your own makeup isn't it? There's always this nature/nurture debate that crops up from time to time.

Scientist: Yes. Which actually seems to have been swinging a little bit in the line of the genetics lately, from my reading of literature. There seems to be more things coming out in which they suggest there is a reasonably significant genetic component. But obviously the nurture one's always got to be important.

KH: Yes. I was wondering, from your point of view as a scientist, how much does human DNA contribute to what a person ends up being like?

Scientist: I suspect quite a lot. I think. You only have to look at your own children, if you have a couple, to realise how different they are from one to another, with pretty similar sorts of inputs from you. You can have treated them, you know, at a certain stage, similarly. Obviously as time goes on these interactions change, but they can seem quite different right from the moment they're born. And most parents say this. They'll say their kids are different.

The scientist stressed the importance of the social relationships established in the context of growing up in a family, but also gave some credence to the importance of genetic factors in determining personhood. She referred to literature indicating a 'swing' towards arguments that favour the significance of heritability in determining who a person becomes.<sup>16</sup> The fertility clinic scientist also attributed this view to her own experience of having children who were unlike in many respects even though raised in the 'same' environment. To suggest, however, that one's children might be the same implies that they inherit the same genetic material, which they do not, unless they are identical twins. Individuals born into the same family at different times and inevitably living separate albeit interconnected lives will also experience a different environment, modified by the presence of other siblings. Further emphasising the

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<sup>16</sup> See Wright (1995) for a recent discussion of the contribution of behavioural genetics to the swing towards the importance of heredity. Paul (1998) cites authors publishing in the 1990s, such as Seligman and Murray, who argue that poverty and the failure to succeed cannot be clearly attributed to people's circumstances. In Seligman's view, "genes explain who gets ahead in America, and why" (cited in Paul, 1998:89). Other influential studies that support arguments about the importance of genetic inheritance include the famous Minnesota studies of twins who were separated at birth, and the Colorado Adoption Project, which concluded that children resembled their biological rather than their adoptive parents (Gladwell, 1998:56-57).

importance of environmental factors, a recent theory suggests that peers have a stronger influence on what a person becomes than do parents (Gladwell, 1998).

Many parents of children conceived by DI raised the issues of heredity and environment in the making of a person. Most contended that people were the 'product' of *both* their genetic heritage and their environment, though some stressed either nature or nurture as being more significant, while see-sawing between the two. Some parents with children conceived by DI were particularly conscious of heredity, or the part that genes played in their child's makeup, because of the circumstances surrounding their decision to use DI as a method of conception, or because of particular outcomes. Allan and Sandra, who had triplets, Edward, Georgia and Juliet, after DI 'treatment' that involved the use of the fertility drug Clomiphene, said:

Sandra: Well, being multiples we're very aware of the genetic and hereditary versus environment situation. And so I think we can see definitely so much that's genetic, but we can also see so much that's environmental, because they have similar attitudes, they do things the same way as each of us. So obviously that's come through observation of us doing things, rather than talking even, but doing things.

Allan: But their basic character is totally different. The three of them, they're totally different characters.

Sandra: The personality, yes.

Allan: The temperament.

Sandra: Yes. Just the way they go about things.

Allan: Although that tends to change a wee bit.

KH: And it's hard to know where that comes from.

Sandra: Well we treat them more or less the same. So, therefore, we feel that the specific differences almost have to be genetic. And the way that we treat them differently now is because of their different personalities.

KH: You were saying that two of them were more like your side of the family?

Sandra: Physically. That's only in looks.

Allan: We've got one boy that's fairly much a boy. He doesn't want to know very much about girls' things. We've got one girl that's very much a girl and doesn't want to know very much about boys' things. And we've got another girl who's interested in both. She'd like to be a tomboy, to get on with Edward and yet she wants to be very much a girl at times. But she needs to keep in good with both, whereas the other girl gets on very well with just herself. Edward needs a little bit of company but not as much as Georgia. Georgia needs a lot of company. Juliet doesn't need any. Edward needs a little bit. And I suppose that's the marked, the most marked difference between the three. Whether that's genetic or a throwback on her side, or something different...we'll never know.

Sandra intimated that they treat the children the same and yet they do not. This illustrates the interactive themes of biology and social environment. Allan raises the point that although one can ruminate on the possible origins of certain human characteristics, what has caused their children to be who they are remains largely speculative.

Another mother of two daughters conceived by DI commented that she was unsure whether her older daughter's interests were genetically or environmentally determined:

Patricia: When I was pregnant, we were given information on a sheet [the donor profile], and things cover his hobbies: he likes puzzles and reads a lot of books, and Tracey's the same. She's very interested in puzzles and loves books. So do we, so I don't know whether that's a genetic thing or not.

Patricia thus raised the prospect that genetic predispositions may be realised or reinforced by environmental factors. Behind this lies the practice of 'matching' donors and recipient couples which assumes the genetic determination of some human characteristics.<sup>17</sup>

Some parents of children raised the issue of genetic and environmental influences in relation to their child's intelligence levels. Stephanie, the mother of three children conceived by DI, each with a very high IQ, remarked that it was difficult to determine the most significant contributor to this: the donors' genes, her genes, or the scholastic environment in which the children lived their day-to-day lives. When asked about this, she said:

Stephanie: That's difficult, because, you see I've got my degree almost on straight As. So where does it come from? And does it matter really? ... It's hard to know because people didn't identify children's ability so discretely when I was young. But you see I know that I was selected out for a university project and looking back now, I realise that it was because I was very able.

So, was it the donor, or was it me? And I mean, certainly in the environment. You see, the kids have been brought up in an environment where...well, last night the television went off at quarter to eight I suppose. I went upstairs and was studying. John [her husband] was working on the computer. And so, the kids just know that that's the way we work, and so they are in that environment all the time, and they've had both John and I studying for the last four, five years...both of us studying. And so, they think it's normal. They're used to having lots of text books floating around, and so I think all these things contribute.

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<sup>17</sup> The practice of 'matching' semen donors and recipients in fertility clinics is discussed in Chapter Five.

While Stephanie speculated about the relative contribution of genetics or environment to her children's high levels of intelligence, Mary and Brendan, parents of two children conceived by DI, speculated whether their son Jason's intelligence was inherited from the donor. They said:

Mary: I can see there are things about Jason that I feel he's a lot like me. And some of the things, I think emotionally wise, I think he is a lot like me. But, um, I think that genetically he's probably brighter than what Brendan and I are.

Brendan: Yeah, that's quite obvious.

KH: Did it make you wonder whether one of the doctors might have...

Brendan: Yeah, well in fact I think they did indicate that it would probably be one of their doctor staff, at the time. Because at the time they indicated the only donors they had was doctors.

Mary: Doctors or medical students, or something. They were getting a lot of university students or medical students that were helping them out at that stage.

While they thought of the possibility of Jason's intelligence being inherited from the donor, Mary commented later that some of her mother's 'side' of the family had gone to university, so she wondered whether her son could equally have inherited his academic ability from them.

For Carla, the mother of a daughter who was conceived by DI, the genetic contribution to her daughter's makeup from the donor was significant in that it meant that she would avoid the debilitating hereditary diseases evident in her husband's family. Carla commented on the importance of genes in determining health status, and argued that while the environment had an influence on a person's development, "a lot of things are born into you". She drew on public narratives and personal experience of children adopted into "good" families who turned out to be "bad", ostensibly because of their genetic inheritance. She even said that she hoped that their donor did not have a criminal background, suggesting that a propensity towards criminality was heritable.

When asked if he thought homosexuality was environmentally or genetically determined (or both), Derek, a gay man who had donated his semen to a lesbian couple, Sophie and Ria, had this to say:

Derek: I think it's totally genetic. I mean, when I was 14, my friends were looking through Penthouses, and pointing at pictures, and telling me how horny those pictures made them. I thought, well, why doesn't that do that for me? What's wrong with me? And the experiences I

went through, I know there is no way that I could have had any other orientation. My father was incredibly anti, he gave me all the books on sex education from every aspect, except homosexuality, and when I'd finished reading all these, you know, over a year he'd sort of taken me through everything. And I thought, well, where do I fit into this? Do I have to do that?

KH: And it was repugnant to you?

Derek: Totally. It revolted me. And I really believe that the issue is love, and this child is going to be surrounded by love, and I think when it comes to sex, when the child goes through adolescence, their sexuality will come out, and I really do not think that has any relationship to the environment. I think the environment gives them a fabulous understanding of the dynamics of same sex couples, and homosexuality and lesbian and also the difference between the two. They'll have a really good understanding of that.

KH: And presumably heterosexuality and homosexuality would be visible to the child.

Derek: Definitely. With all the relations. There are Sophie's parents, and sisters and brothers, and with Ria's mother. Ria's biological mother is now living with a woman, but Ria was adopted. But you know, she's going to be surrounded by a good mix.

Like many of the men and women in Weston's study of gay and lesbian families, Derek maintained that his homosexuality was innate, rather than environmentally determined (1991:39). Although he argued that being gay was genetically determined, his argument appears contradictory in that he does not appear to think of homosexuality as inherited.<sup>18</sup> His parents were not gay and he assumed that his daughter, who would be raised in a lesbian-headed household, would one day 'discover' her own sexual identity, which would not be determined by the fact that her three 'parents' identified as lesbian or gay. He also suggested that his daughter would be surrounded by people who modelled either homosexual or heterosexual relationships, so, from this point of view, her environment would provide a good basis from which to 'choose' her sexual identity.

Pippa, mother of a daughter, Elspeth, conceived by DI, raised the issue of the significance attached to genetic ties in the bonding between parents and children. Sean, Pippa's husband, did not think his lack of genetic tie to his daughter had been detrimental to his bonding with his daughter. He played down the significance of heredity and commented that Pippa had an identical twin who was "not particularly identical any more". Pippa said that since she and her identical twin had grown up and led separate lives, they had made the conscious decision not to look the same. This raised the spectre of the role of agency and freedom of choice in determining the

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<sup>18</sup> This presupposes, however, that what is inherited has to be evident, whereas genetically it could be recessive.

path of human development, even for those who share the same genetic inheritance. The question arises, however, whether it is freedom of choice that makes identical twins different. Wright (1995:62) cites behavioural geneticist Eaves, who argues that the quest for freedom is genetically determined, and that “freedom means something about the capacity of a human organism not to be pushed around by external circumstances”. In this view, freedom could equally make identical twins alike, or not alike. Both Pippa and Sean contended that whether genetics or environment was implicated in what a person is like at any stage of their life was not significant: what was more important to them, was the relationship they developed with their daughter.

Sean: How she is, is not particularly important. She is as she is, and she's our daughter.

Pippa: I just want her to grow up happy and healthy, and if she doesn't have that much in common with us, she might not have anyway. I know some children who can't stand their parents.

Sean: That's right. I mean, thank God I've got nothing in common with my family!

Pippa: If you were too much like your Mum you'd have me worried. She's really nice but she's got some characteristics that I would just shrink to have, eh Sean?

Sean: Yes.

Sean and Pippa's comments exemplify the simultaneous use of discourses of environmental and biological determination. On one hand, they suggested that their daughter's genetic makeup was unimportant compared to the quality of their parent/child relationships. On the other, they appeared to acknowledge that certain family characteristics might be genetically determined, and Sean believed (or hoped) that he had avoided inheriting some 'undesirable' family traits.

In contrast to Sean's position on the relative unimportance of biological ties, Sean's mother, was keenly aware of the lack of a biological tie to her granddaughter. She worried that her son would not love a child conceived by DI as much as Pippa did because of the lack of a genetic tie. For this reason, she favoured adoption for them, rather than DI.<sup>19</sup>

Joan professed to feel that there was something missing in her relationship with her granddaughter, knowing that she was not related to her genetically. She remarked:

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<sup>19</sup> See Chapter Four for further discussion of this issue.



Joan: There's something missing there. And yet I love her just the same. But, someone said one day... "You must be very proud of her." And I thought, "Well I can't be proud for myself, because I haven't had anything to do with it." So there are little things missing. Mm.

KH: So you might be proud if she was somehow part of your [biological heritage]?

Joan: Yeah. I'm proud of her, but for myself I haven't got anything to be proud of, have I, because she isn't anything to do with me that way...genetically, she isn't. But whether it has advantages other ways, I don't know. You see them as they are without that strange binding.

Joan is proud of her granddaughter, but at a distance. She introduced the idea that blood 'ties' inexplicably bind people together. In this respect she conforms to what Strathern has identified as the view in Euro-American cultures that biological ties are fixed, immutable and primordial (Strathern, 1992a). At the same time, she felt that perhaps the 'strange binding' caused by genetic ties could cloud one's perception of one's relatives, and without this, perhaps, she could therefore have a more 'honest' relationship with her granddaughter. Nonetheless, because of the significance of the biological connection for her, she did not consider her granddaughter a 'real' relative, or someone who would be interested in her own ancestry. Joan therefore did not think Elspeth would be interested in her old family photos which she thought she might pass on to her niece who, unlike her granddaughter, was her 'blood' relative.

Like Joan, Andrew, father of two DI daughters, spoke of the ambiguities of being the father of children conceived by DI: they were *his* children and yet they were not his. He and his wife Annie said of their relationships with their children:

Annie: Well, you do sort of think of them as *my* children. I quite often hear you saying, "They're *your* children."

Andrew: They are.

KH: But they're yours too in the sense that you are their father, if not the biological father.

Andrew: Yes. The birth certificate suggests that, so legally yes.

KH: And emotionally?

Andrew: No.

KH: They're not your children?

Andrew: Well, they're not. They're not my lineage, no.

KH: So that biological connection is important to you?

Andrew: To me personally, yes. But I accept that I've got...I've got two lovely kids that I can't have. I've got them. You've got conflicts here I know, but that's how I operate, how I think...It's no different from Annie having a prior arrangement with someone else and having children.

Andrew explored the idea that his children were not *his* children in the sense that they were not related to him biologically. At the same time, he acknowledged a social tie with his daughters and a bond that was growing over time. He said:

Andrew: I've still got a complete tie to them, but I can just say...that's me saying it coldly, "they're not my kids." They are very much my kids. I'm developing their personalities. I'm influencing their personalities as they grow up, so they're very much my kids, have always been my kids, but you've got this wee cold hard fact at the end; they're not my kids, which is getting lesser and lesser and lesser, and they're getting my kids more and more. It's part of the process of...

Annie: It's just time.

Andrew *simultaneously* drew on understandings about his children being his, and not being his, even though these understandings were in tension with each other. It is not that they are one or the other. Even though the children felt more like they were his as he developed a social relationship with them, Andrew acknowledged that they had always been his children and he had a "complete tie" to them. His analysis illustrates how the discourse Strathern (1992a, 1992b) identifies as dominant is not the only discourse operating in Euro-American culture. This is an illustration of other discourses in use.

Kathy, divorced mother of a daughter conceived by DI, was acutely aware when her child was born that she was *her* genetic child, rather than her husband Joel's. This was partially because their daughter was conceived when, against his wishes, Kathy had attended the clinic for one final insemination, this time with a female friend, and became pregnant with Melissa.<sup>20</sup> As a result, Kathy felt responsible for the decision to have Melissa and was uncomfortable assigning their daughter her husband's surname only. This decision was further reinforced by the knowledge that Joel's surname was not the name of his biological father, but his stepfather, a fact that he had found out as an adult. For Kathy, the family name was symbolic of a genetic connection and bloodline. Her awareness of her daughter's genetic connection to an unknown person rather than her husband was heightened by finding out soon after she was born that her daughter's blood group was different from his.

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<sup>20</sup> According to Kathy, Joel had been with her for the two previous inseminations and then had directed her to have no more because he could not "handle it". Having resisted his directive, and attended the clinic for another (this time successful) insemination, she subsequently felt she had become pregnant without his approval.

Kathy: When they told me at 4am that this was a different blood group, I remember thinking, you know, this is an enormous decision I've made because I kind of felt solely responsible at the time, and at the time, Joel and I had to discuss what name we would put her under, and I felt very uncomfortable at the time putting her under just the name Foster. It went to the name Reid-Foster in the end, because I felt it was unfair to give her a name that had no connection insofar as genetics [was concerned]. Reid is my maiden name, and Foster is Joel's name and I chose at that point...before that I had become Reid Foster and I chose at that point, we decided to name Melissa Reid-Foster. That was important to me because I felt that the connection came through me, and really, I felt, needed to be more solidly on my part.

While Kathy's rationale for naming their daughter was based on the fact that Melissa had no biological connection to her father, it seems significant, however, that Joel was not the active, intentional social father at the time that Kathy conceived. This highlights the point raised by Ragone (2000:61) that parenthood is associated with the intent to conceive, to take the initiative to create another human being and take on responsibility for parenting. Kathy's subsequent concerns about the lack of a biological connection between Joel and Melissa thus suggests that social and relational issues are getting coded by genetic connection. Nonetheless, family was important to Kathy, and she was interested in her own family genealogy, which she knew about, dating back to the sixteenth or seventeenth centuries.

KH: So you're interested in genealogy?

Kathy: Yes. I mean family is important to me. I mean it's a solid thing.

KH: So it's important for identity?

Kathy: It is an identity. I guess, as a child I had a lot of difficulty having an identity anyway because we'd moved here from overseas and we had no family connection here.

KH: Where did you come from?

Kathy: They came from England and Europe and moved around.

KH: So you think that might be why it's important to you?

Kathy: It's possibly why it's important to me. Family is important. But also knowing who you are is who you are. Saying you're from Harry Brown when you haven't...I mean there's nurture and nature, as I described to these children...which is how I've put it to them. It's a combination of both.

Some extended family members of an infertile male reported having initial concerns about the arrival of a child who was not genetically related to their family member. Jeremy and Christine, whose niece Madison was conceived by DI, said that they had discussed the issue of the child not continuing their brother's/brother-in-law's blood

line. When asked if they had thought of Madison as somehow ‘different’<sup>21</sup> because she was not biologically related to her father, they said:

Jeremy: Yeah. We did talk about that between us, and we always said that we would certainly try to treat her as equal as anybody, and, um...

Christine: I think the answer is yes, I would, that I would think that she's a bit different and...before she was born, yes, but...

KH: Did that change when she was born?

Christine: Probably not right when she was born, but more as you get to know her as a child, and you're more around her and she just becomes a part of the family and Richard and Belinda's baby and her, you know, "origin" becomes irrelevant because you're all just being families with children.

Jeremy and Christine perceived a need to *try* to treat their niece as if she were not ‘different’. The fact that this need is identified, however, indicates that the two grandchildren are not seen as equal. They were also concerned that Jeremy and Richard’s parents would relate to their grandchild, who was conceived by DI, in the same way that they related to their son, Thomas, who was their biological grandson.

Christine: We did talk about her being treated differently and things like that, but I don't...I think it was more how your parents would treat her in comparison to Thomas, rather than how we would treat her because, oh yes, I've thought through that further. Because they were both grandchildren, but I guess my feeling was that Thomas was their grandchild, um whereas genetically Madison wasn't, and I was very aware that they would have to treat them the same, whereas for us she is only our niece, if you can understand the distinction. They have to treat them the same, but she's our niece and he's our son and so...

Jeremy: It's a different relationship...it's a very different relationship, whereas for my parents they're both a grandchild and...equal ranked grandchildren, so...

Christine: And they are. Your parents try very...yeah...they do try hard, and I think, yeah, but I think now that she's here...

Jeremy: Less and less so.

Again, Jeremy and Christine’s comments indicate that there was a perceived need to try to treat the children as equals, when “in fact” they were not. Another paternal uncle of three nephews conceived by DI, expressed disappointment at not being able to see inherited family characteristics in the boys.

Matthew: Yes. It's a shame we can't see the van den Berg personality...not personality...

KH: Character traits?

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<sup>21</sup> The conceptualisation of children conceived by DI as ‘different’ or ‘special’ is discussed in more detail in Chapter Eleven.

Matthew: Yeah, exactly, of our side of the family, and I suppose the Dutch heritage, although there is...I believe one of the donors was of Dutch origin for two children, I believe. But, I don't know. It's just...I don't see any...apart from the blond hair, you don't see any of Joe I believe in the children. Mind you, not that it's always the case...I mean your children don't always look like either the mother or the father or both, but just, it would have been nice to say, "oh, he's got Joe's nose, or his ears or his eyes", or something. Or, "that's a young Joe", or you know, although our parents aren't around any more, it would have been nice to be able to say "Joe looked exactly like that when he was seven years old", or whatever. But I mean, that's not the case now anyway, because they can't say that, but...

Matthew's comments raise the issue of family resemblance, and the way that comments about shared family likenesses serve as a signifier of biological links between parents and children and connectedness to the wider family network. Chapter Eleven includes a more in-depth discussion about the way that people draw on the public narrative of physical resemblance to craft family identities and relatedness.

While some participants were concerned about biological ties or the lack thereof in their families, others professed to have little interest in concepts such as bloodlines, inheritance or biological ties. For these families, the social relationships were regarded as more significant and interesting than bloodlines or knowledge of one's family genealogy. Sharon, the paternal grandmother of Chris and Diane's son, who was conceived by DI, said she had little interest in genealogy or biological ties. She claimed that she and her husband Doug had not thought about their grandson as being somehow 'different' because of the lack of a genetic tie to them. She said:

Sharon: Well, even if Chris is our son, knowing him and that he really wanted a family, um, no, it never entered our head. At one stage, when Diane and we were talking, she did say to us, well her Mum and Dad would be in a different situation to us, because, you know, it would still be part of their, you know, genealogy, or whatever, but that never went through our head, you know, at all.

When asked about the significance of being biologically related to family members, Sharon replied:

Sharon: I don't think there is any. If the love is there, it's there for any child. Well, as far as we're concerned, um, I'm afraid that we've got lots of families around that, well, that we're an extra granny and granddad to, um. I mean, actually sometimes I say, gee, the family's getting a little bit big sometimes [she laughs]. Probably because my Mum and Dad come from Scotland and I had no immediate family, and I think probably you just sort of bring in others and you take on their children too.

Like Sharon, Diane and Chris, the parents of Scott, who was conceived by DI, privileged the social ties over genetic ties when they said:

Chris: It's the environment...the environment's got more to do with it than the actual genetic side.

Diane: A certain amount of it must be genetical [sic], but, you know, biological...you know, you can see that he's just the image of Chris in a lot of things that he does, and mannerisms and that sort of thing, even though he doesn't look like him. And interests, you know, he's picking up the same interests...

This illustrates the way in which kinship can be constructed through physical resemblance and other sorts of likenesses, such as sharing similar mannerisms and interests. Revealing the extent to which such likenesses can embody kin relations, a 'social' father of a son conceived by DI who appeared in Snowden, Mitchell and Snowden's study said, "I keep thinking, well perhaps he *is* mine" (1983:141).<sup>22</sup>

Diane's parents held views similar to Chris and Diane's about the relative significance of biological and social ties in the context of kin relations. Diane's mother, Marion, said that the family rarely spoke of their forebears, that she and her family had little interest in the previous generations, and that she had been quite satisfied to know just 'the basics' without delving deeply into her family history. She tended to think of biological ties in terms of passing on certain health-related predispositions, rather than in kinship terms, and said:

Marion: ...sadly we've got an alcoholic line running right through our...or seem to have...through our family, so we're very aware of that. Um, and Diane's watching that one and going to have him...she's already started to sort of educate him on the thing because we feel that it's very...it's inherited...it's in the genes. So, we've got that worry, but other than that you know, you look out for the usual things like asthma and that sort of stuff, but that's about all.

Marion thus drew on a medical or health discourse in relation to notions of heredity, and emphasised the strength of the social tie between her son-in-law and grandson. Like Marion, Janine, the maternal grandmother of Erica, who was conceived by DI, stressed the closeness of the relationship between Erica and her father Peter. Janine professed some interest in her own grandparents, but like Marion, she thought of genetic inheritance in relation to possible predispositions to forms of disease. When asked if she had any particular feelings about bloodlines, inheritance or biological ties, Janine said:

Janine: I don't know. I suppose, you know, I think I sort of look back. Sometimes I ask Mum even now about her grandparents and things like that. But not really for bloodlines. Um, and I guess that if there was an adoption, if Mum had been adopted, for instance, I would be asking

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<sup>22</sup> Chapter Eleven includes a discussion about physical resemblance and the social construction of biological ties.

her about her adoptive parents rather than the...yeah, no I don't think the bloodlines are important.

KH: So for Erica, she'd find out about Peter's parents and family?

Janine: Yes. The only thing that I can see she would need to know, that could be important is health, you know, genetic health lines or anything like that.

One maternal grandmother of a DI child claimed that an interest in issues of inheritance or bloodlines was only relevant to those with money or property, and that her family did not belong to that social class. Discussion emerged in the interview in connection with the continuation of family names that illustrated the way in which family names act as a symbol of biological links, even if the biological link does not exist. Joanne, the maternal grandmother of Madison, who was conceived by DI, thought that her granddaughter should be raised as a Johnson and a Morgan (the family names of her biological mother and social father) and that the donor would not enter the picture in terms of Madison's genealogy. She said:

Joanne: But I really do wonder with the donor thing if that sort of thing is going to go back to the donor father. Where it would be...to be hoped in Madison's case, Belinda and Richard are going to instil in her that she's a Morgan and a Johnson, you know, that's what I imagine. I don't know what Belinda feels about it, but you know, now and again Richard gets upset about her learning [the language of his family of origin] and that, and I'm saying, "No Richard, it's good for her to learn two languages", you know and I find I'm encouraging the other side. It affects me not at all, but I just find it's easier to...and I think that's what I would try and encourage Richard and Belinda is that she's from the Johnsons and the Morgans, and not really look for that other person, because, yeah, I hadn't really thought about that (she laughs). Yeah, in the family tree, when it comes along. But then surely the donor *gives*, so they haven't got another offspring for their family tree, they give to a couple so that it's their child, so therefore it's a Johnson/Morgan mix. It's not a somebody-else in the wings. I don't know. You raise a lot of questions (she laughs).

Joanne reveals an interesting tension when considering whether or not her granddaughter could ever be considered part of the donor's family tree. On one hand, she hoped her granddaughter would be raised as progeny of the Johnsons and the Morgans and not as part of the donor's family tree. This raised the prospect of the gift of gametes transferring 'relatedness' from one person to another set of persons. According to Edwards and Strathern (2000:159), through the symbolism of the gift, a potential future chain of relationships and claims that could have been traced through the child's genetic tie to the donor is truncated, "deactivated in advance, by pitting one set of truths ('biological') against another ('social')". At the same time, Joanne could not ignore the 'reality' of her granddaughter's biological origins, leading her to question whether this was the "right way" to conceptualise the relationships.

## Conclusion

This chapter illustrated how people in families with children conceived by DI draw on discourses of the biological and the social to make sense of their familial and kin connections. Recent sociological theorising on families points to the diversity of family forms, and the changing and fluid aspects of families in Western societies in the late twentieth and early twenty-first centuries. These analyses suggest that families using donor insemination to conceive their children should be seen as just one of a number of families negotiating complex kin relations. Some parents indicated an awareness of the diversity of forms of relatedness in contemporary households and saw their families as relatively conventional in comparison to reconstituted families. Also highly relevant to this analysis of families with children conceived by DI is contemporary social anthropological theorising which focuses on the implications of the use of assisted conception for notions about 'family' and 'kinship'. These theorists explore the 'destablisation' of the natural basis of human procreation and reproduction, and challenge the notion that biological ties are the cornerstone of kinship and family formation. Social anthropological theorising on kinship and 'relatedness' has focussed attention on issues about 'nature' and 'biology' and the relationship between the 'biological' and the 'social'. Theorists such as Carsten (2000) challenge and destabilise the taken-for-granted dichotomy between the 'biological' and the 'social', and have shown that the division between the 'biological' and the 'social' is somewhat blurred. Moreover, Edwards and Strathern (2000) have highlighted the ways in which the 'biological' and the 'social' can be distinguished and/or combined.

Drawing on recent sociological and social anthropological theorising on 'the family' and 'kinship', the chapter has shown how discourses of the 'biological' and the 'social', 'nature' and 'nurture', are often simultaneously used to attribute meaning to familial and kin connections. An analysis of research participants' talk reveals an interweaving of the themes of the biological and the social, nature and nurture. While the movement back and forward between these discourses often appears contradictory, it is often also used to justify a person's situation, or to make it appear less threatening. Biology is revealed as an important symbol of relatedness that can be articulated and embodied in many ways such as through naming practices. Parents



of children conceived by DI actively construct social connection between fathers and children, often in the idiom of biology and physical resemblance. Couples thus rework the nature/culture dichotomy to make sense of their familial relationships as they perceive them. While some privilege biological ties over social ties and vice versa, in many cases the importance of both biological and social ties appears simultaneously in the people's talk. For many couples the major factor in the formation of families is the social connection between two people who are committed to a joint set of actions and responsibilities that inhere in parenting as a practice. As a result, the 'origins' of the child are secondary to the family relationships established over time.

Most parents believed that their children were the product of both heredity and environment; thus the themes of biology and the social environment interacted. While discourses of nature and nurture were often combined, in some instances heredity was separated out as important, particularly in terms of the determination of health status, and to some extent in the child's level of intelligence and physical appearance. For some participants, the lack of a biological connection qualitatively affected the meaning of the relationship between the parent and child or grandparent and child. What is revealed here, however, is that social and relational issues are being coded by genetic connection. For some, biological connection was a means of establishing an identity; for others, it was of little interest other than in the context of medical or health issues. For most, the 'biological' and the 'social', 'nature' and 'nurture', were intricately intertwined and inseparable in the process of conceptualising family and kin connections.

PART TWO

**Negotiating DI Practices**

## **Preface to Part II – Negotiating DI Practices**

This section of the thesis focuses on the social and clinical processes involved in conceiving a child by DI. Chapter Four examines the issue of infertility and couples' responses to a diagnosis of male infertility, and their decision-making in relation to pursuing the project of parenthood. Drawing on the theory of narrative identity, the chapter draws attention to the disruption to people's narrative identity caused by infertility, and the subsequent replotting of lives that takes place for couples who find out that they cannot conceive a child without assistance. The chapter shows that couples' experiences of infertility and choosing to become parents by 'alternative' means is embedded in wider kin relations, and shaped by dominant discourses about the meaning and significance of biological ties. For most couples, the decision to conceive with the help of an anonymous sperm donor was fraught with ambivalence, but this route to parenthood was regarded as the best, or only option in the circumstances.

Chapters Five, Six and Seven explore the clinical context in which couples have conceived through DI. Chapter Five examines the discursive and relational strategies used by two New Zealand DI programmes which act as brokers of sperm and intermediaries between donors and recipients. The construction of sperm donation as an 'altruistic gift' and the complexities and difficulties of recruiting and screening donors are a focus of attention. The chapter draws attention to the paradoxical effects of a system organised around the principle of anonymity that also takes into account the perceived 'rights' of children conceived by DI to identify the donors in the future.

The politics of access to DI treatment are the focus of Chapter Six. While DI programmes were traditionally established to 'treat' couples with male factor infertility, since the passing of the Human Rights Act, 1993, fertility clinics are not permitted to discriminate against groups of people such as lesbian couples or single women who seek to conceive by DI. Health professionals, however, act as the ultimate gatekeepers to access to the scarce resource of donor sperm. The final chapter in this section focuses on couple's shifting and changing identities as they negotiate the multifaceted world of the fertility clinic and emerge having achieved the success of entering the normal pregnancy trajectory.

## Chapter Four

### Pathways to Donor Insemination

My infertility resides in my heart like an old friend. I do not hear from it for weeks at a time, and then, a moment, a thought, a baby announcement or some such thing, and I will feel the tug – maybe even be sad or shed a few tears. And I think, “There’s my old friend.” It will always be part of me (Barbara Eck Menning, founder of Resolve,<sup>1</sup> cited in Noble, 1987:36).

#### Introduction

This chapter examines how couples came to have a child by donor insemination. It looks at the critical moments, the contingencies and the processes involved in making a decision to have a child in this way, and the particular route(s) taken towards this life experience. The chapter explores the stories that individuals tell about their experience of infertility, their desire to have a child and their decision to use DI as a method of achieving parenthood in circumstances where their first choice – to have a child biologically related to both parents – has been thwarted. Most of the couples included in this study claimed to have suffered some of the emotional difficulties often associated with infertility that are discussed in the academic literature and appear in ‘infertility stories’ told by the popular media.<sup>2</sup> In the context of this study of families who have one or more children conceived by DI, stories that create an identity of ‘infertile’ have been told from the position of having circumvented

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<sup>1</sup> Resolve, a United States non-profit organisation devoted to issues revolving around infertility, was founded in 1974 by Barbara Eck Menning. A similar organisation in New Zealand, the New Zealand Infertility Society, was established in 1989 and incorporated in 1990 to: provide a national network for people affected by infertility and a national voice on issues; advocate for improved equity and effective care; provide a forum for discussion; raise public awareness on infertility causes, treatments, implications and impacts; provide consumer representation on medical, legal, ethical and policy issues; ensure information is available in the community so that people can make informed life choices to protect and enhance fertility; support research into infertility.

<sup>2</sup> The psychological and social consequences of infertility have been widely discussed in the literature on infertility and assisted human reproduction. See, for example, Bierkens, 1975; Menning, 1980; Harrison, O’Moore, O’Moore and McSweeney, 1981; Adler and Boxley, 1985; Sandelowski and Jones, 1986; Miall, 1986; Matthews and Matthews 1986; Williams, 1990; Abbey, Andrews and Halman, 1991, 1992; Daniels, 1992; Becker, 1994. Examples of personal stories of the experience of infertility appear frequently in the popular press and in Infertility Society newsletters (see, for example, Pathways, the magazine of the New Zealand Infertility Society).

infertility (if not having ‘cured’ it).<sup>3</sup> Parenthood has been achieved through DI. Thus, for the couples participating in this research, each story of infertility exists alongside a ‘DI success story’.

The chapter draws on a number of sociological theories, including Mills’ notions of private troubles and public issues (1963), recent sociological theory on the constitution of narrative identity (Somers 1994; Plummer, 1995), and analysis of the discursive production of selves (Davies and Harre, 1990). Social theorists of narrative have drawn attention to the ‘storied’ nature of culture and society. For example, Plummer (1995:5) contends that

... society itself may be seen as a textured but seamless web of stories emerging everywhere through interaction: holding people together, pulling people apart, making societies work.

Plummer (1995:16) is not so much interested in the narrative structure of stories, but with the grounded social and political conditions of their emergence. Like the sexual stories now being told when once, not so long ago, they were shrouded in silence, so too are stories of surviving and surpassing infertility being produced, coaxed and consumed (Plummer, 1995:21). Everywhere interaction emerges around story-telling: public narratives are created by the public telling of private troubles, and people in turn make sense of their private troubles and personal suffering by drawing on these public narratives. Social theorists such as Somers (1994) and Plummer (1995) consider the ontological nature of narrative: narrative is not merely representational of a situation or an event, but actually constitutes meaning and identity. Furthermore, Somers (1994:614) argues that new research shows that stories guide action and that people construct identities by locating themselves or being located in a repertoire of emplotted stories. She argues:

...it is through narratives and narrativity that we constitute our social identities...all of us come to *be* who we *are* (however ephemeral, multiple, and changing) by being located or locating ourselves (usually unconsciously) in social narratives *rarely of our own making* (1994:606, original emphasis).

Somers suggests that we draw upon a repertoire of stories available to us to make sense of our lives and the lives of others. These are the public narratives from which

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<sup>3</sup> The issue of infertility ‘treatment’ circumventing rather than curing infertility is discussed in Chapter

our ontological narratives derive. Somers (1994:625) argues that the “narrative” dimension of identity presumes that we can understand social action only if we recognise the various ontological and public narratives in which actors are emplotted. Moreover, we need to recognise that the narratives people use to make sense of their lives are mediated through a vast array of social institutions and practices.

The stories that people tell of the discovery of infertility and the subsequent pursuit of alternative ‘options’ for having a baby show how people discursively position themselves in a society which values parenthood as an important ‘rite de passage’ or initiation to adulthood (Cameron, 1990). According to Cameron, New Zealanders do not have discrete “reasons” for having children: the rationale is communicated in a complex of interactions that are not explicit (1990:122). Furthermore, it is not just any child that people want, but their “own” child; and it is not just any kind of parent that they want to be, but a “real” parent (Cameron, 1990). This chapter examines the discourses that couples and their kin draw on to make sense of the experience of infertility, their desire to have children, and the options available to them to achieve the desired goal of parenthood.

### **Reactions to infertility: private troubles and public issues**

For most couples, the path towards having a child by DI began with their unsuccessful attempts to conceive and the subsequent discovery of medically diagnosed male infertility. For most, the news of infertility came as a shock. Some men reported that finding out that they were infertile was a “real blow” that left them feeling “devastated and isolated”.<sup>4</sup> While it took some time to come to terms with, the majority found ways of coping with this outcome. Men’s ability to do this had profound implications for their self-esteem and intimate relationships, as revealed by the following examples of the experiences of Caroline and Mike and Andrew and Annie. Mike and Caroline recalled their experience of finding out that Mike was azoospermic (he had no sperm):

Caroline: It certainly hasn’t affected *our* relationship at all. In fact going through it at the time probably enhanced it more than anything, because it was something that was really personal

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<sup>4</sup> Other references to participants’ reactions to infertility appear later in this chapter, for example, in connection with considering the alternative strategies for parenthood.

just to both of us. And I was probably really quite concerned just for Mike, you know, the fact that it's probably more acceptable for a female to be infertile than what it is for a male. Eight years ago, it certainly was. I mean it's okay [for a woman] to turn around and say, "well, you know, I'm sorry but I can't have children" but for Mike to turn around and say "well, actually I can't have kids, because I don't have any...or my sperm don't have any goodies in them or whatever it is!" I mean, it's quite different and it's quite hard I think for a male to accept.

KH: [To Mike] Did you find it actually quite difficult to accept?

Mike: Oh yeah, I did. It was quite hard. It's quite a shock. I wasn't really expecting it when I was asked to give a second sample. But I suspect that it was, the first time, a zero. They didn't say that, but just said, "would you like to come in and give a second sample?" I got told over the phone. [The doctor] was Caroline's doctor, not mine, and he told me, but he was quite good. But at the time I got over it without any problem. I didn't feel like advertising it to anyone in particular.

In contrast to Mike and Caroline's experience, Andrew and Annie stood out as having had a particularly difficult time, over a protracted period, confronting the issues associated with Andrew's azoospermia. The following part of this section focuses on their particular case, not because their narrative is representative, but because it highlights some of the complex and intense emotional issues that can arise for individuals and couples in connection with infertility.

Annie and Andrew had been trying to conceive for three years before they saw a doctor to determine the cause of their infertility.<sup>5</sup> As in Mike's case, two semen analyses showed that Andrew was azoospermic. They said:

Andrew: June 1990. That's when I was told I couldn't have children. We were infertile, basically. At that stage the doctor told us that we could look at the donor insemination programme. We took a year [to decide].

Annie: That was at the same time wasn't it? That bad news, and then this good news straight afterwards. I don't know whether that was actually a good thing.

Andrew: There was no pressure. It was just an idea he threw out to soften the blow, from my point of view. It is a shock to find out you can't have kids. The cause is unknown, although the assumption is mumps a long time ago, followed by glandular fever.... I had glandular fever very severely at 18-19 years of age, which took about five years to go. So I had it quite severely. So that's partly the reason I guess. But then no-one can tell me.

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<sup>5</sup> Three years appears to be a long time when considering that infertility is generally constructed as the failure to conceive after a year of unprotected sexual intercourse (Coney, 1999c:11). According to Coney, this definition of infertility is based on the statistic that 80% of women will get pregnant after a year of unprotected intercourse. However, after three years 93% will do so (Coney, 1999c:11). A book recently published by a New Zealand fertility clinic advises that decisions about when to investigate infertility depends on the couples' wishes, but should generally be initiated as soon as some concern is felt (Fertility Associates, 1998). Most other participant couples had begun infertility investigations after about a year of 'trying' to conceive, though some women who quickly suspected something was wrong, sought medical advice after only a few months.

Annie: It would be nice for you to know, wouldn't it? But never mind.

For Andrew, June 1990 was a critical moment in his life: he learned that he could not become a biological father. He drew on the narrative of the “we” of infertility, which constructs infertility as a ‘couple problem’ rather than an individual problem (Dickens, 1990:23-24). Annie had doubts that it was helpful for them to hear about DI as an option for having children before they had had a chance to grieve and perhaps ‘come to terms’ with their infertility.<sup>6</sup> Andrew, on the other hand, believed the doctor mentioned DI as a positive counterpoint to the negative results of his semen analysis. Andrew and Annie had on-going concerns about the lack of a satisfactory explanation for Andrew’s azoospermia. In relation to determining the cause of male infertility, the director of a New Zealand fertility clinic said:

Dr C: Well, there are a number of reasons, but by far the most common cause is what we call idiopathic, we really don’t know. Things like undescended testes, for example, but for by far the most, there’s no explanation. Pituitary problems themselves do account for a few.

In the absence of strong evidence of the reasons for their infertility, Andrew and other infertile men and their partners recounted stories of critical moments in their lives that might account for their infertility. These were narratives about episodes or incidents such as childhood illnesses, “coming off the handle bars once too often”, being kicked in the testicles by a bull, hit by a squash ball, or born one of a twin. But, in the absence of a scientific explanation about exactly how or when infertility ‘happened’, the uncertainty remains. This illustrates Shilling’s argument that amidst growing technological advancement and ability to control the body in high modernity, many uncertainties remain about what the body is and how it should be controlled (1993:183).

Uncertainties about bodies and how they function (or do not) add to the feeling of loss of control over their bodies and their life choices that many infertile couples experience (Noble, 1987:30). At a recent symposium hosted by the New Zealand

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<sup>6</sup> Noble (1987:30-36) identifies the stages of grieving that many infertile couples experience as defined by Elisabeth Kübler-Ross and others. These include: shock, denial, anger, isolation, guilt, depression, grief, and (hopefully) resolution. Annie was concerned that she and Andrew did not go through this grieving process before considering donor insemination as an alternative to childlessness. Menning (1980) argues that doctors should not casually suggest DI in the absence of proper screening or counselling of couples. DI, she contends, should be considered as an *alternative* to infertility, not as a *treatment*.



Infertility Society, a number of attendees contended that for infertile people, feelings of loss of control over one's body and the decision to become a parent is the major cause of stress associated with infertility.<sup>7</sup> Extended family members of infertile people also experienced feelings of loss of control or helplessness when confronting their relative's infertility. Some parents of infertile men said they were distressed to find out about their son's infertility and wondered if they could have done anything to prevent it. The father of one infertile male said that he wondered if their son's infertility was caused by an undescended testicle, which he and his wife noticed when their son was at primary school. He said:

Jim: And we noticed it in the bath, I'm sure. We took him to the doctor and they made an adjustment. It might have been a bit late. That's just what I think might have happened, but whether that is right I don't know. I've got no evidence one way or the other, but he did have a problem there when he was going to primary school, and we got it fixed when we knew about it. So, maybe that was the reason. ...You don't go around with a boy when he's seven or eight or something looking at him and saying "Is everything all right down there? Have they dropped?" and what have you (Jim and Marjorie laugh). But maybe you should, maybe you should, you know. I just feel a little annoyed with myself that we probably didn't find out earlier, if that was the cause. I don't know. But, nothing you can do about it now, I suppose.

Jim's comments suggest that he felt a degree of guilt or responsibility for his son's infertility. However, the degree to which unknown variables might have contributed to the infertility highlights the impossibility of covering every contingency. As a result, as Jim pointed out, there is little that couples with male factor infertility can do but explore other strategies for becoming parents, which means creating alternative self-identities.

Finding out that one cannot be a biological parent as planned requires people to re-examine and replot their lives (Kirkman, 1999). Drawing on theory of narrative identity, Kirkman (1999) has studied the ways in which women with infertility develop new narratives for and about themselves. She argues that if we accept that our lives are constituted through narrative, we can then understand "the profound challenge confronting a person whose identity, narratively constituted, has been disrupted by the discovery of infertility" (Kirkman, 1999:1). This idea about the disruption of identity indicates the degree to which being a parent is generally assumed as part of adult identity. Kirkman maintains that revising the plot of one's life means more than making "a decision" about what to do next (1999:4). It means

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<sup>7</sup> 'Winning with Stress', NZIS Symposium 2000, 11-12 August 2000, Christchurch New Zealand.

having to interpret the life already lived, the goals and directions of one's life and understandings about self-identity.

Individuals responded differently to the diagnosis of male infertility, depending on a number of factors, including the type of diagnosis and the degree of commitment to fulfilling the role of biological parent.<sup>8</sup> For Andrew, the news of infertility totally disrupted the story he had told himself (and perhaps others) about his life as a husband, a father and as a human being. He said of the events that occurred after the news of infertility:

Andrew: We went through the process of deciding whether to stay married.

Annie: Oh yes. Andrew wanted a divorce because he couldn't give me children, and that was a very big thing for you, wasn't it?

Andrew: Yeah.

Annie: It never came into my mind, but...

Andrew: The purpose of life is to reproduce. That's my thought, so therefore, take that purpose away, what does one have? Not a lot. And why should I deny someone else that purpose when I can't deliver? ...I had no purpose in life: suicidal tendencies, loss of job, financial pressure. I'd been the complete person, but I'd lost my reason for living. Why are we here? You take all those fundamentals. I might not be normal but that's the way I view life. So...might not be normal...

Andrew and Annie's dialogue reveals a sharp distinction between their own personal narratives as individuals who reacted to infertility in different ways, and their shared narrative as a married couple who were planning to have children together. Andrew positioned himself as unworthy of staying married because he could not fulfill what he perceived as his purpose in life as a husband: to procreate with his wife. Clearly for Andrew, a dominant narrative in the constitution of his identity as a married man was becoming a biological father.<sup>9</sup> Thus, for Andrew, infertility became a significant "private trouble": the values that he deemed important were considerably threatened by his inability to become a biological parent (Mills, 1963). Andrew's expectation of

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<sup>8</sup> Noble (1987:30) maintains that the depth of loss each person feels about infertility varies from frustration to extreme depression. Matthews and Matthews (1986:646) hypothesise that "the greater the commitment to biological parenthood, the greater will be the identity shock brought about by infertility and involuntary childlessness, and the more negative the effect on self-esteem".

<sup>9</sup> Writing on the emotional effect of infertility, the chief executive officer of Britain's Fertility Association, ISSUE, claims that for infertile men the feelings of failure and powerlessness are especially acute. This is because men are brought up to be providers, to be successful and they are generally in the position of power (Rice, no date).

himself as an individual supports Cameron's contention that for most pakeha New Zealanders, having children is important to their sense of biological and social completeness (1990:99.). In this sense, infertility is also a "public issue" (Mills, 1963:395-396) because the values cherished by the public at large are not fulfilled by infertility. The perception of himself as less than a complete person led to a loss of confidence and a sense of futility<sup>10</sup> which carried over into other areas of his life: his work, relationships with others and his marriage. Eight years after the initial discovery of infertility in 1990, Andrew and Annie said:

Andrew: I've just got over the grief of not being able to father children now, recently, in the last 9 months, 12 months. A long process.

KH: And basically you went through that process on your own?

Andrew: Basically, yes.

Annie: Wouldn't talk to me for the first five years. It's actually only in the last 9 months that we've actually talked about it. Is that true?

Andrew: Yes.

Annie: I couldn't bring it up. It was just "Don't talk about it. I don't want to talk about it." So I was just sort of shut off.

Andrew's extended period of raises the question of whether a refusal to express one's emotions and receive feedback from others delays the process of being able to develop alternative narratives for living one's life. Williams (1996) argues that people with chronic illness undergo a process of 'narrative reconstruction' whereby a person's biography is reorganised to take account of their illness and changed relationship with the world in which they live. Similarly, Becker (1994) contends that discontinuities in life force people to reconstruct some semblance of continuity in their lives. Andrew claimed to have "shut off" his emotions: pursuing parenthood was, he thought at the time, more important than acknowledging his feelings about being infertile. To restore a sense of continuity after the disruption of infertility (Becker, 1994), he focused on constructing himself as a 'father' to two daughters conceived by DI. This was part of the project of shaping his life "as a rational, autonomous, responsible individual seeking to maximise [his] potential and achievements as a worthy person" (Lupton and Barclay, 1997:18).

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<sup>10</sup> A recent national survey of the experiences of couples with fertility problems in the UK reported that 20% of respondents said that they had experienced suicidal feelings. One in three also reported not fully

Lupton and Barclay (1997:17-21) have argued that parenthood is a “project of the self”. They cite Zygmunt Bauman’s (1996) claim that individuals in contemporary societies embark on “pilgrimages” which, unlike in pre-modern times, are accomplished without leaving home. Each pilgrimage constitutes the ‘unfinished project of the self’, the on-going attempt to fashion self-identity in a world that is full of uncertainties and risks (Lupton and Barclay, 1997:17). Andrew’s decision to embark on fatherhood through DI as a ‘project of the self’, while concealing his emotions, can be linked to dominant discourses in Western thought which privilege reason above emotion. Williams and Bendelow (1996:125) cite Bordo (1986) who referred to the ‘Cartesian masculinization of thought’ – the separation of mind from body, nature from culture, and reason from emotion.<sup>11</sup> In this view, emotions are dismissed as ‘irrational’, private, inner sensations which need to be “‘tamed’, ‘harnessed’ or ‘driven out’ by the steady (male) hand of reason” (Williams and Bendelow, 1996:125).<sup>12</sup>

At the time of the interview, Andrew had reached a point where he believed that it was beneficial for him to talk about his infertility. He said:

Andrew: I feel more relaxed about it. I feel I can talk to anyone about it now, whereas before I couldn’t...none of your darn business. I wouldn’t be talking to you today if I didn’t feel comfortable about it, and I guess, it’s just time I guess. I went to a psychologist and they couldn’t help me. I’m a strong personality. No-one tells me what to do. I make up my own mind. I can be influenced but, yeah...

Annie had tried for several years to get Andrew to see a psychologist, and when he finally did, the session had not been a success as far as he was concerned.<sup>13</sup> The ‘trials and tribulations’ experienced by Andrew and Annie in connection with his

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understanding the nature of their own or their partner’s infertility (Kerr, Brown, and Balen, 1999).

<sup>11</sup> According to Williams and Bendelow (1996), this dominant view in Western thought has also contributed to the neglect of emotions in sociological thought and practice. They maintain that only in the past decade or so has a distinct body of work emerged in the sociology of emotions.

<sup>12</sup> Although not fully explored here, Lupton and Barclay (1997:21-24) suggest that a psychoanalytic approach may be more useful than discourse analysis when exploring people’s emotions and passions. Its usefulness, they claim, lies in its focus on “the emotional, the contradictory, the fragmentary and disordered subject rather than the ‘rational’, the conscious and the unified subject” (1997:22).

<sup>13</sup> Psychologist, John Snarey, contends that a longitudinal study of married men, including infertile men, revealed that early responses to the discovery of infertility and the way they dealt with the problem tended to have a lasting impact on their lives. The study measured levels of marital happiness and “generativity”, the term referring to the mid-life stage in Erikson’s theory of the life cycle (Snarey,

infertility illustrated Kirkman's (1999:8) suggestion that "infertility is a complex vicissitude which women [and men] tend to experience rather like Tolstoy's unhappy families: in their own way". Their story also bears the hallmarks of the modernist stories identified by Plummer (1995:54). Having endured many years of *suffering* in silence about his infertility, Andrew had reached an *epiphany*, a point where the silence had to be broken, and as a result he became *transformed*. Theirs is a story of surviving and maybe surpassing infertility.

For most couples faced with male infertility, the passage of time became significant. Time was spent trying unsuccessfully to conceive, having tests, waiting for test results, grieving for the loss of a child they will never have, exploring the options, waiting for medical appointments, going onto waiting lists for fertility treatment, and so on. Joe and Ella said:

Ella: Then the sperm count came back and it was nil, and from then on we just sat round trying to decide...we sort of left it for six months or so.

Joe: More than that...about two years I thought. It was a fair while, because we were dumbfounded. Yeah I reckon we were there nearly two years, I really do, until we sorted out what we were going to...basically we found out and went into shock and that lasted about 12 months and then we started finding out about the sort of avenues we could take.

Ella: Mm. We didn't really realise we had to wait.

Joe: No. That added to it I think. It might have been six months while we sat on our hands and did nothing, and then we started talking about what we were going to do, and then we tried to find out where to go.

Like Andrew and Annie, Joe and Ella had a sense of being stunned by the discovery of infertility and of time spent waiting. Time was also perceived by some as an important factor in the process of coming to terms with infertility and 'moving on' to the next phase in one's life. Helen and Patrick, said:

Patrick: You know, when you find out you can't have children, it's a real blow.

KH: Did you find it took some time to comes to terms with?

Patrick: Sure. When I went home up to the North Island I told my mother, she cried, she blamed herself....

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1988). A recent report on infertility services in New Zealand states that "infertility causes as deep and enduring a sense of loss as many chronic illnesses" (Gillett, Peek and Lilford, 1995:66).

Helen: Yeah. I think that infertility is the big hurdle. That is the tough one. It's not the donor insemination or the can you or can't you...it's just this black and white thing that's right there, you can't change it. So you have to learn to accept that before you can move on. And that was harder than having the donor.

In contrast to those men (like Mike, Andrew, Joe and Patrick) who had no sperm, for those who had at least some sperm, the outlook appeared less black and white. Some men with a diagnosis of oligospermia (a low sperm count) responded by adopting a variety of 'lifestyle' changes in the hope of raising the sperm count to improve the chance of being suitable candidates for IVF (which, if it worked, would enable them both to be biological parents). Diane and Chris claimed that the time they spent focusing on drug and vitamin regimes in a bid to raise Chris's sperm count gave them the time to grieve for the loss of their ability to have a child biologically related to them both. Diane said:

Diane: So that went on for about three years in total from when we started to when we actually decided...well, we were told that IVF wasn't an option because the sperm count wasn't enough. So then we decided to go for DI and at that stage it was, more or less, a natural progression wasn't it? We'd gone through three years of like trying everything we could to try and follow up Chris's aspect of it and by the time we made the decision to actually go for DI, it was almost a huge relief because we were stepping off that roller-coaster onto a slightly different one....<sup>14</sup>

I do think that it's quite important that you do have that time to...for other couples I mean...that you do have that time to come to terms with things 100%, because I think, then, if you do that, then the road will be much smoother. If you suddenly jumped into it, you know...if we'd jumped into it back when we first found out [things might not have turned out so well].

Although the possibility of them both becoming biological parents was eventually closed to them (and ICSI<sup>15</sup> was not available at that time in New Zealand), Diane and Chris were able to experience their decision to have a child by DI as a "natural progression". This occurred in a series of episodes framed as "roller-coaster" rides, which ultimately led towards achieving their goal of parenthood.

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<sup>14</sup> The metaphor of the roller coaster is frequently used by infertile people to describe the emotional highs and lows that accompany pursuing parenthood through a variety of methods of assisted reproduction. While these methods offer 'hope' and the chance of becoming pregnant, the frequently-experienced failure to achieve pregnancy through AHR leads to contrasting feelings of disappointment and despair.

<sup>15</sup> Intracytoplasmic sperm injection (ICSI) is a medical procedure which involves the injection of a single spermatozoon into the oocyte with the aim of achieving fertilisation and the subsequent implantation of the zygote (fertilised oocyte) in the uterus. This method of conception is discussed later in this chapter.

Infertility stories tend to highlight the private and personal aspects of the pain and suffering incurred by infertility. In this way, infertility appears to be constructed as a private trouble, rather than a public issue (Mills, 1963:395). However, another narrative about infertility emerged in this study: infertility is not an uncommon experience.<sup>16</sup> In other words, while many initially felt that they suffered alone, they began to realise they were not alone in their plight. Angus and Joanne, the maternal grandparents of a child conceived by DI, said:

Joanne: [DI] is quite commonplace. That's what quite amazes me how many children are donor children nowadays really. It's quite common really.

KH: You mean you've suddenly heard more about them?

Joanne: Yeah, yes. Maybe it is because we never listened before. I don't know (she laughs).

Angus: It's quite amazing. I have two people at work this week who came up with similar things happening with their children.

KH: I suppose it makes you think that perhaps infertility is more of a problem these days than it used to be?

Joanne: Well, I do wonder.

Angus: We actually talked about it with the two people I spoke to...we talked about different things and we were trying to come up with some bright ideas about why it is happening. And we looked at all the different scenarios of, you know, maybe it's chemicals, and yet some of the chemicals that we dealt with 50 years ago were more dangerous than what the ones are nowadays, so we were trying to balance it up.

Joanne: I think it's stress of life. I honestly do. The pace of life...

Rather than perceiving infertility as purely a private trouble, these grandparents framed it as a public issue possibly related to aspects of contemporary life, and therefore affecting people from all walks of life. This illustrates how public narratives are created by the telling of private troubles.

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<sup>16</sup> The lack of a standardised definition of 'infertility' makes it difficult to estimate its prevalence. According to Greenhall and Vessey (1990), British studies have shown that one in four women have had difficulties with conceiving or periods of sub-fertility at some time in their lives. About one in eight women experience sub-fertility when attempting to conceive their first child and one in six their second child. It is estimated that only 3% of women remain involuntarily childless (Greenhall and Vessey, 1990; Gillett, Peek and Lilford, 1995). The only New Zealand data available comes from a survey of contraceptive practice of 1,000 women conducted between 1983-1986. This indicated that 3% of married women aged 25-54 could be classified as infertile, but the authors suggested that their definition may have led to underestimation of the prevalence of infertility (Paul, Skegg et al, 1988, cited in Brander, 1991:10; Gillett, Peek and Lilford, 1995:13). Gillett, Peek and Lilford (1995:9) estimate that infertility affects about 25% of couples at some time in their reproductive lives, and 3,500 new referrals for infertility services are made each year in New Zealand.

Some couples had family members who they knew also had been diagnosed with male infertility, or who they suspected had similar problems to their own. Brendan, whose infertility was caused by a malfunctioning pituitary gland, said that two of his nephews had the same condition. Brendan's sister said of her two sons:

Shona: When they went to high school, or just before, I took them to the doctor at Port Chalmers and I told them about Brendan, so he decided he would test them for it, so he sent them to Christchurch and we waited for three weeks and yes, it was the same condition.

KH: Are there any symptoms?

Shona: The genitals don't grow. They don't progress into puberty. They were just at high school age, so they were lucky compared to Brendan, because Brendan was 21 when he found out, whereas my kids were on treatment [hormone injections] that enabled them to go through puberty. They've got to have the injections all the time.

Shona had become both an aunt and a grandmother through DI. Male infertility was, therefore, a family health issue for Brendan, Shona and their kin.

### **Support Networks**

While some couples chose to keep the matter of their infertility to themselves, others shared information about their infertility with 'supportive' others, including friends, family members and counsellors, or joined infertility societies and support groups. Some couples, and the women in particular, had become actively involved with their local Infertility Society as a way of 'networking' and becoming more knowledgeable about the options available to them. Belinda and Richard, who had initially sought counselling, later joined the Infertility Society. Belinda said:

Belinda: I think first of all, [we got support] from the counsellor, because I was taking it quite badly, you know, I found it quite hard, to cope with all these new things. It was very mind-boggling, but the counsellor knew about the Infertility Conference that was here in 1995, so I took time off work and tootled off to learn and broaden my horizons about the whole thing. So it was actually there that I met a girl I worked with, who, unbeknown to me, was involved in the Infertility Society, and I didn't join the society as such. I joined the committee. There we found our information. There I found out that I should be off to see Dr A.

As a way of increasing support from family members, Belinda and Richard also invited close relatives to attend Infertility Society meetings so they too could be better informed about male infertility.



Alice and Peter had joined the local Infertility Society when they first began DI treatment. They said:

Alice: [Fertility clinic staff] actually sort of encouraged, or suggested the Infertility Society was available. And we ended up getting quite a lot of information through the newsletter over the first few years. It's only recently that we've started going to meetings. We were waiting so long for someone to get the donor support group going again, that I ended up volunteering my name to do it. So, since then I've had calls from the clinic to call other people about such and such. We've had one meeting. We're about to have another one at the end of next month.

Peter: There were three or four interested couples at that time including ourselves.

Like Alice and Peter, Diane and Chris wanted to keep abreast of information about infertility and new reproductive technologies through information disseminated by the Infertility Society and by reading books on the topic. Diane said:

Diane: We belong to the Infertility Society and if we were in Auckland I'd probably belong to a support group or something. I've actually thought about setting up a DI support group, but I've yet to do it. The clinic don't have a newsletter as such, do they, though in the New Zealand Infertility newsletter they usually have a little update, and I'm always reading bits and pieces. Like, if there's a new infertility book in the library I'll take it out and whip through it, just see what's in it.

Like Alice and Peter, Diane perceived that belonging to a group or society with members who shared a similar parenting experience would be beneficial. Similarly, Sophie and Ria, a lesbian couple who had conceived a child with the help of a known donor, had thought of establishing a group for lesbian parents, because, although they knew of other lesbian couples with children, they did not know them personally. They said:

Ria: It's becoming more and more obvious to us that it's important for us to be part of the gay community and part of a community where there are more and more lesbian mothers, so that we can create as normal a space for Lydia as possible.

Sophie: There's a guy who I was talking about before, he's got friends, a lesbian couple, who are quite keen on setting up a lesbian mothers' play group which would be quite good. I sort of mentioned it to Jennifer, and she was quite keen.

KH: It would be good to have a supportive network of gay people, but it's just a small community here I suppose?

Sophie: Yeah it is. I think there's quite a large community up in Auckland. They've got play groups up there, and quite a closeknit support group happening up there, but it would be nice to start a little one down here. But I've heard of...I've probably counted about six, maybe even eight lesbian couples who have had babies down here, that I've heard of.

Both Diane's and Ria and Sophie's circumstances raise the issue of the difficulty of establishing support groups of people in small communities who have constructed parenthood through similar 'alternative' means.

Attending Infertility Society meetings was not regarded as beneficial by all couples. Some had attended meetings and/or support groups but had not felt entirely comfortable with the experience. Carla and her husband Ben had decided to use DI to avoid passing on hereditary diseases in his family (polycystic kidney disease and heart disease) but had been unable to link with others in the Infertility Society who had chosen DI for similar reasons. Carla said:

Carla: I went along to a meeting of the Infertility Society, but it was before that I knew that I had endometriosis, and I almost felt like I didn't belong there, because I had chosen DI and these poor people had had this imposed upon them from birth, sort of thing. And even though it was really important for me to talk to people about this donor insemination business, I was like, I felt really uncomfortable. So we belonged, and I've still got lots of the newsletters and things, but we didn't go to the meetings because we felt almost that we'd done something wrong by choosing this when other people had to suffer it because of nature. So, in that way we felt really isolated, because I don't know of anybody else that's done it through choice, through a medical condition. Nobody. And at the support group that they got up and running afterwards, none of those were doing it for the same reason as us either.

Because they had *chosen* to use donated sperm, instead of their 'own', Carla felt that they were positioned as 'outsiders' within a group of people who were essentially *involuntarily* infertile. Thus, she felt marginalised within a marginalised group.

For some couples, attending Infertility Society meetings with others who shared the same difficult plight of being infertile, was not perceived as supportive. Mary and Brendan said:

Mary: We went along to one of their meetings about infertility and donor insemination and all that sort of thing.

Brendan: Yeah, it doesn't really interest us to get involved with that at all.

Mary: No, and I found it was just awful because they were just all people like us that couldn't have children, and I remember saying to one of them, because I knew that we were on the list and we were number such and such. And all she said to me, is "Oh, you've done quite well. We're such and such, and we're way down the list" ...you know (she laughs), and it just made me feel terrible. I thought, well that's not much support is it? She was further down the list than what we were. And I thought, this is supposed to be a support group. But it was just a whole lot of people feeling really sorry for themselves that they couldn't have children, and, um, it was just not really much support at all.

Experiences such as these question whether support groups comprising similarly disadvantaged people really do support. They also raise the issue of the possible benefit of seeking one-to-one professional help to address some of the grief issues that emerge as a result of infertility.

Like Belinda, Sarah had decided that she needed individual counselling to cope with issues that emerged for her as a result of what she perceived as the trauma of infertility. She said:

Sarah: I was abused as a child and I knew as soon as we found out that we couldn't have kids, I knew...you know how they say, one trauma often brings back another past trauma, and I knew that I would need counselling, and Tim didn't want to have a bar of it. I got into a very vulnerable position where I nearly made some bad judgements, and Tim still wanted to have nothing to do with it, and I just said, "Don't come and be counselled, but come and sit next to me, which he did, and, course, once you're there...(she laughs).

And it was quite good. You know, he wasn't going there for him, but we had a male and a female and he talked to the guy and I talked to the lady, and then we came back together. It was only three sessions and it was just enough to get out some of the stuff that we really wanted to say that you couldn't say to them directly. And then I stayed on for another couple [of sessions] to deal with the abuse that I had had as a child. And it was just, I mean, it's not trivial by any means, because it's had a bearing on our relationship. Of course, he only went for the couple of sessions, and he was okay (she laughs). And he was quite pleased...he was more worried about my childhood experience than this whole infertility stuff, but I knew the whole combined traumas, I would need someone to talk to, because, I just couldn't cope with it all at once.

While Sarah sought professional counselling, some couples turned to close friends and family members for support. However, some family members felt that they could not provide the support their infertile relatives needed because they were unfamiliar with infertility or DI, and also felt powerless to help. Peter's brother said:

Roland: I'd be quite happy to talk to Peter about it. But you feel pretty useless in terms of trying to provide some sort of support for the person, because you know so little about it yourself...he knows more because of the contacts he's had...you don't feel as if you can contribute a lot, except perhaps views that are exactly contradictory to what might be best for them. And you feel very reticent about actually making comments that steer them down a route that might be quite different. It was always a very softly softly approach with me, because, I mean, I'm a fairly dogmatic type of person. You can be too outspoken sometimes with these things, and I think it's good to just be a listener for them. I think it was something they did want to talk about because I sensed that they did want to get family reaction, but not that they necessarily knew that at the time. They were just trying to be open, so there was no great mystery about something that was going on in the background that everyone talked about but no-one talked about.

Like Roland, Jeremy and Christine felt somewhat inadequate when it came to supporting their infertile family members, Richard and Belinda.<sup>17</sup> They believed that they were the “wrong people” to be supportive of Richard and Belinda at a time when they appeared to most need support because Christine was pregnant with their first child. They said:

Christine: I think that when they told us that DI was what they were going to do, we just said to them that we were really pleased that they could do that. I was glad because I'd had such a difficult time with Belinda and her with me that I was glad that she was going to be pregnant, because then that [problem] would be solved. She could be pregnant and I knew that that, above anything else, was what she wanted to be, and it was awful because we wanted to help them, but there was absolutely nothing we could do.

Jeremy: We were the wrong people to support them at the time.

Christine: They probably needed us. But we couldn't really be there could we? Well, we could, but then I think mainly it was every time Belinda saw me getting bigger and bigger and it really was rubbing salt in the wound a lot.

Christine and Jeremy appeared to believe that the difficulties in their relationship with Belinda and Richard at the time were partly because of Belinda's envy of Christine's pregnancy.<sup>18</sup> For her part, Belinda did appear to find other people's pregnancies a difficult reminder of her own inability to get pregnant with her husband Richard. Referring to the time after they discovered Richard's infertility, they said:

Richard: [To Belinda] You were just like a walking zombie for about six months.

Belinda: I was a total zombie at work. I'd burst into tears for no...

Richard: Especially working in a bank, you know. I mean you've got two, three other young girls, young ladies there...

Belinda: All falling pregnant all the time. It was a constant reminder. It was horrible.

Richard: That was the hardest thing. As soon as somebody became pregnant, or...

Belinda: I'd come home and be all upset.

Richard: And then my brother and his wife became pregnant, and they knew that we were having problems. But, you know, you can't stop them having their own family!

Belinda: And every time we went to...no we couldn't stop them having their excitement and that, but every time we went to Richard's parents, the whole conversation was just phased

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<sup>17</sup> Jeremy and Richard were twin brothers but, whereas Jeremy was fertile, Richard was diagnosed with germinal cell aplasia (he did not possess the cells that produce sperm in the testicles).

<sup>18</sup> It is possible that Christine's pregnancy merely exacerbated an already, at times, tense relationship with Belinda: in the interview, Christine referred to them being “very different” from one another. This is also hinted at above when Christine refers to the “difficult time” she and Belinda had with each another.

around babies, and I just sat there and thought “I don’t want to be here”. That was the hardest thing. And then we went there one time, and they were getting the crib out of the roof, and they asked us to stay for lunch, and I just said “No, I’m out of here, I’m not putting up with this”. They didn’t realise what they were doing, but I just found it...yeah. I wanted that excitement first, ‘cause Richard’s the oldest twin, you know (she laughs).

Richard: By eight minutes (he laughs).

Belinda appeared to believe that because Richard was the first-born twin, that he and she had a ‘right’ to be the first to conceive and bear a child: that this was the ‘natural’ order of things. This supported Becker’s finding that infertile people undergoing fertility treatment espoused the belief that life should be “predictable, knowable and continuous” (1994:90). Belinda was also distressed by, and critical of, Richard’s parents’ focus on Christine’s pregnancy because it was a painful reminder of their inability to conceive. According to psychologist Aline Zoldbrod, envy or jealousy of others who are pregnant is common among infertile women (1993).<sup>19</sup> A recent national study of couples’ experiences of infertility and fertility treatment in the UK, however, found that while many survey respondents experienced emotional difficulties associated with infertility (including tearfulness (97%), depression/isolation (84%), anger (84%), inadequacy (72%)), only 2% claimed to feel envy/jealousy of pregnant women (Kerr, Brown, and Balen, 1999:936). While envy and jealousy are not very laudible emotions, and few may claim to experience them, it is possible that Belinda was experiencing a range of emotions associated with her experience of infertility. In her struggle to make sense of her situation, she found it difficult to contend with others’ pregnancies.

Ultimately, although most couples were able to get some support from some quarters, many felt that they experienced their infertility and treatment on their own. When asked who provided the most support through the process of coming to terms with their infertility and having children by DI, Helen, the mother of two sons conceived by DI, said:

Helen: We did it all pretty much on our own. And it is something that you have to deal with yourself. Although family might know about it, they’re only aware of the big picture. It’s bad enough

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<sup>19</sup> Commenting on this phenomenon, Zoldbrod argues that jealousy of others who are able to get pregnant and carry a child to term is “probably the most troublesome and shameful feeling surrounding infertility. Whoever is envied, and whoever does the envying, envy has a destructive, dehumanizing effect on both” (1993:10).

to go and have a baby, but going to have donor insemination [adds to the stress]. And then you have to write a cheque for a baby, if you like.

Helen raised the issue of the dual stress that couples had to contend with themselves: the problem of infertility, and the need to pay to become parents through the use of reproductive technologies. The latter links to arguments against the introduction of the market economy into the area of parental love, and criticism of the commodification of babies through the use of reproductive technologies.<sup>20</sup>

### **Considering the options for parenthood**

The decision to conceive a child by DI was generally made in the context of comparing this option with others. While revising the narrative ‘plots’ of their lives included some degree of acceptance of the loss of a biological connection at least between the father and the potential child, each couple retained a narrative identity as a parent (Kirkman, 1999). When exploring the alternatives to not having children, Peter and Alice decided that they would at least try some of the options available to them to become parents. They said:

Peter: We weren't really good candidates for anything except donor, at that time, and ICSI hadn't sort of come on the scene quite then and we weren't prepared to go to Australia. We'd sort of made this agreement that we weren't going to do anything too heroic, and we were going to be sort of reasonable and rational about it because we had um...

Alice: Some friends who had lots of operations and who did IVF, and, you know...

Peter: They didn't have a very good time, and although that was quite a few years beforehand, we sort of... we both see other opportunities as well, and saw it opening up in perhaps a different path for us as a couple. So, had we not been able to have any children, we probably would have made a good life for ourselves anyway, although, we would have always had regrets had we not sort of tried.

Alice and Peter's deliberate engagement in the project of becoming parents relates to arguments explored by Shilling (1993) about the relationship between the body and self-identity in high modernity. Whereas in traditional societies, he argues, people's identities were received automatically through ritual practices which connected people and their bodies to long established social positions, high modernity makes self-identity *deliberative* (Shilling, 1993:181, original emphasis). According to Shilling:

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<sup>20</sup> These arguments are explored in Chapter Five.

...identities are formed reflexively through the asking of questions and the continual re-ordering of self-narratives which have at their centre a concern with the body. Self-identity and the body become 'reflexively organized projects' which have to be sculpted from the complex plurality of choices offered by high modernity without moral guidance as to which should be selected (1993:181).

The following subsections explore the different strategies for achieving parenthood considered by the participants in this research: adoption, ICSI, and DI with a known or an anonymous donor.

### **Adoption: a road less travelled**

When considering the options for parenthood, most had given some thought to adoption. In relation to the choices available to them, and their decision to use DI, Alice and Peter said:

Alice: Well at that point our options were either donor, adoption, or none, weren't they? That was what we had - all that was available. And I think we liked the low-tech side of [DI], didn't we?

Peter: The low tech and the kind of ease of access was quite important. And low cost...I guess that was a consideration...

Alice: But also we liked the idea that the child would be kind of more *ours* in a sense than if it was an adopted child.

Peter: Yes. If it was sort of biological...

Alice: Sort of half biologically ours. Also there's that sense of...ownership's not the right word ...but, you know, with open adoption these days it's so complex and you're sort of taking on another family, and it's all a lot more difficult.

Peter: The relationships are a lot more complex I think.

While they had considered adoption, Alice and Peter liked the idea of having a child that was "half" theirs in a biological sense,<sup>21</sup> and were uncomfortable about the complexity of the relationships they associated with adoption.<sup>22</sup>

Sarah, the mother of two adopted children, Rob and Phoebe, a child conceived by DI, Charlotte, and a foster child, Amy, corroborated Peter and Alice's concerns about the possible demands of open adoption on families with adopted children. She said:

<sup>21</sup> In their study of families with children conceived by DI, Snowden, Mitchell and Snowden (1983:87) commented that this was the most often cited advantage of DI in comparison with adoption.

<sup>22</sup> Many of the issues that emerge in this study about couples' preferences for DI over adoption were raised by couples included in Daniels' New Zealand study of 54 couples who had children by DI, most of whom had previously considered adoption (1994).

Sarah: The social issues of having a donor child are just far superior to adoption. We could have put our name down for adoption again, but we would rather have another donor child, because you get to do the...experience the whole process. Um, you are more accepted by everybody else...not that we need that. But it's just so many less complications. Like, last week, we had to get Rob's birth family all organised, you know, because they want to have visits and stuff. So we saw Rob's birth family, Amy's birth family, then Aunty Judy arrived, so that was three birth mothers in a day, and I just thought, thank goodness we don't have to do anything for Charlotte's.

Although they had accepted the social obligations as “part of the deal” of open adoption, Sarah said that they nonetheless felt somewhat “stretched” at times and, in retrospect, would opt for the fewer social commitments associated with having a DI child.

While some women said they preferred DI to adoption because they wanted to experience pregnancy and the birth of a child, some men saw no reason to deny their wife the opportunity of going through pregnancy and childbirth. Andrew said that if they were to adopt, he would have preferred to adopt an older child rather than a baby. He and Annie said:

Andrew: Being a father isn't about having a baby, it's about developing a young person, I guess. Others might see having children as more the baby stage. I feel that later on is when you develop a strong bond perhaps. Is that what I'm saying? I don't know. The other thing, I guess, you don't want to cheat your wife out of the experience of having babies, either. Adoption cheats them to the extent that it's not part of you. And I know that Annie felt that 'it doesn't matter if it's not part of me', but in my view I was still cheating her out of the opportunity of being able to have a baby herself.

KH: [to Annie] Did you like the idea of going through a pregnancy?

Annie: Yeah. I think that was something I sort of wanted. It did appeal to me to have a baby rather than adopt, though adoption was there for me, but it wasn't for Andrew.

Andrew: I'll justify that by saying that friends of ours who...their second marriage, where she is not going to have the ability to have children because he's fixed...I can see that she felt robbed that she couldn't have children. It's just the way you think. An important part of a woman's [identity] ... it's the way *women* are. You've had a complete life if you've had children maybe. Is that correct? Or is it in my mind?

Andrew constructed pregnancy and birth as an important part of a woman's identity. Later, he also indicated that he would feel emotionally closer to his wife's biological child than he would to an adopted child.



Connected with the preference of many couples to have at least some biological relationship to the child was the idea that DI was preferable to adoption because children conceived by DI were less likely to suffer from issues relating to their relinquishment for adoption by their birth parents.<sup>23</sup> Diane, the mother of Scott, said:

Diane: The other thing I feel quite strongly is that because people often compare adoption and DI, and I don't actually think...there's certain similarities...but like with adoption, you can't get away from the fact that a baby's actually been given away by the natural parents. Whereas the only reason that Scott's here is because we wanted one so much and someone was good enough to actually donate some sperm. So I hope that the rejection issues that adoptees have...I hope that Scott doesn't have those.

When stating her preference for DI, Diane drew on discourses about the possible harmful psychological consequences for the adopted child.<sup>24</sup> For most couples, DI was considered the “second best” option after having a child biologically related to both of them, while adoption was considered a possible third option if DI had failed. For many, however, adoption did not even appear to be an option because of the institutional constraints of the time. Meredith, who had enquired about adoption, said:

Meredith: I was in my thirties, and the waiting list was actually closed, and by the time it had opened up and I filled in a form, they rang me up and said, you know, you're wasting your time. I was too old, and I wouldn't be considered. Or, from their point of view, they didn't feel that people...the girls who had babies would consider somebody my age, and that it was better to let me know now. So DI was the only option.

Other couples who had investigated adoption discovered significant barriers to doing so: being over 30 years old, the small numbers of babies available for adoption and the lengthy waiting list.<sup>25</sup> Added to this, some considered adoption undesirable, citing the negative experience of others. Mike, the father of two children, said:

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<sup>23</sup> For example, in *The Primal Wound*, Nancy Newton Verrier hypothesises that the severing of the connection between the child and biological mother causes a “*primal or narcissistic wound, which affects the adoptee's sense of Self and often manifests in a sense of loss, basic mistrust, anxiety and depression, emotional and/or behavioural problems, and difficulties in relationships with significant others*” (1993:21, original emphasis). Parents considering adoption are often aware of these assertions and seek to avoid being parents of children at risk of such ‘wounds’.

<sup>24</sup> While adopted children are also constructed as ‘much wanted’ and ‘chosen’ by their adoptive parents, Verrier (1993) argues that the fact that the child was at one time connected to another mother can never be completely ignored. She argues that while adoptees might understand the reasons why they were relinquished for adoption, the feeling of abandonment as a baby nonetheless remains with “*each and every adoptee all his or her life*” (Verrier, 1993:25, original emphasis).

<sup>25</sup> An article in *North & South* magazine (Nissen, 1990) reported on the reduced numbers of babies available for adoption in a socio-political climate in New Zealand that supported young women to keep their babies, rather than have them adopted. The article claimed that the then Department of Social Welfare (now the Adoption Information Services Unit in Child Youth and Family) had no qualms

Mike: The reality was that adoption was virtually impossible, and literally you had no guarantee as to what you were getting. My brother and his wife had two children of their own and they had a blood disorder and they adopted two, and the two they've got are...they're a real handful, and for want of a better word, below average IQ. So, I mean, I was aware of that, and I thought, yeah that's fine, but if you get someone's unwanted baby, they don't want the baby, how have they looked after it? Where has it come from? You know nothing about it. So, for me, adoption was quite undesirable, under those terms. People had been using DI or AID or whatever you like to call it for many, many years, especially in terms of our cattle, beef industry...agriculture had been using it for fifty years, so it's not as if it was untried.

Mike's concerns about the 'risks' of adoption link to notions that in the 'risk society' opportunities, hazards and ambivalences of biography increasingly have to be interpreted and dealt with by individuals alone (Beck, 1999:75). Drawing on his evaluation of the outcome of adoption within his family, Mike had decided that adopting someone's "unwanted" baby carried greater risks than having a child conceived under the auspices of medical science and legitimated by agricultural practice. While views such as these are based on a narrow field of experience, and cast adoption in a negative light, it should be remembered that Mike is speaking from the position of being happy with the outcome of becoming the father of two daughters conceived by DI.

While these couples had opted for DI rather than adoption, for many family members, and relatives of the infertile male in particular, adoption appeared at first to be a more familiar and acceptable option than DI.<sup>26</sup> By and large, family members said that they were not consulted about their relatives' choice to conceive a child by DI. Rather, they were told that this was the plan and their views on the decision were not sought. Reflecting on the time when she heard that her son Sean was infertile and that he and his wife Pippa were going to try to have a child by DI, Joan said:

Joan: I think at first I was sad for him, that he couldn't have children of his own, which came as a bit of a shock. Then, I think my second reaction was, I think I'd prefer them to adopt...I just thought that somehow or another the affection for the child might be more even. I was a bit afraid that Pippa would love the baby more than Sean. I didn't really know. It was just a first reaction.

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about telling couples in their 30s they were too "old" to adopt, and that their job was to place babies in the "best possible situation with regard to the birthparents' wishes" rather than to supply babies to people (Nissen, 1990:71).

<sup>26</sup> Some relatives of mothers participating in this study suggested that DI as an option for having children was perhaps less of an "issue" for family members on the female side because they had a biological connection to the child no matter who was the genetic father.

KH: So you thought that it would be important for your son to bond to a child, that he be genetically tied to that child?

Joan: Yes, yes. Well I know how I felt myself with my own...with him when he was small. I think that every parent thinks that their child is perfect and that maybe he wouldn't feel the same.

Joan was concerned that an asymmetry would exist between her son and daughter-in-law in terms of the love they felt for their child if they had a child conceived by DI. She implied that her daughter-in-law would have the unfair 'bonding advantage' of being genetically tied to the child while her son was not.<sup>27</sup> As a result, she believed that adoption would provide a fairer solution to the problem of her son's infertility.<sup>28</sup> Like Joan, Christine, another family member, favoured adoption for her infertile brother-in-law Richard and sister-in-law, Belinda. She said:

Christine: I think the only concern I had was I was scared that maybe one day their marriage would be unhappy, and because the child was genetically Belinda's, that that would cause even more friction and that was...if I ever had any hesitation about them making that solution, that was it...that I was scared that it would backfire on Richard.

Christine was concerned that Belinda might have more of a claim to their daughter than Richard because of her biological connection to the child, and could potentially place Richard at a disadvantage.

### **ICSI: the 'complete' genetic/biological connection**

Concern about asymmetry between parents when one is the biological parent and the other is not is one reason for the appeal of new conceptive technologies, such as ICSI, that enable some infertile men (who must have at least a few sperm) to become biological fathers.<sup>29</sup> ICSI essentially enables people with male factor infertility to pursue their 'first choice': to have a child genetically/biologically related to both parents. The technology thus epitomises the new ways in which nature is being technologically assisted (Franklin, 1995). ICSI, which has been practised in New

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<sup>27</sup> For a discussion of the issue of asymmetry between the parents of DI children, one of whom is the biological and social parent and the other only the social parent, see Lauritzen (1993:89-95). For a discussion of the issue of asymmetry among the couples in this study, see Chapter Eleven.

<sup>28</sup> While research has shown that some couples prefer DI to adoption because they perceive that being able to experience the pregnancy facilitates bonding with the child for both the mother and the father (Daniels, 1994), Joan appears to be more concerned about DI creating an 'unevenness' in the bonding process.

<sup>29</sup> For men who have no sperm in the ejaculate, techniques such as microepididymal sperm aspiration (MESA) and testicular sperm extraction (TESE) can be used to remove sperm from the epididymis (a duct behind the testis along which sperm passes to the vas deferens) which can then be used in ICSI treatment (Coney, 1999c:14)

Zealand only since the mid-1990s, was not an 'option' for many of the couples included in this research, at least when they were attempting to conceive their first child. Since its arrival, however, ICSI has constituted another option for couples to pursue in their parenthood project: one with the added attraction of enabling both parents to be biologically related to the child. When asked if the relatively recent availability of ICSI as a means of assisted conception had affected the demand for DI, the director of a South Island fertility clinic said:

Dr A: It's probably a little bit lower because there are options now for people that weren't there before. I mean, some of those with vasectomy reversal would go to IVF/ICSI type, with sperm extraction. But there is still a group of people that can't afford those sorts of treatments and will choose DI. Or there's others who've tried those things but haven't enough to go on so will go to DI. But, I mean, there are still people who you can't treat with IVF.

KH: Yes. So there will be a need for DI?

Dr A: Yeah, there'll be a need. You see you're comparing treatment at the moment that costs...they're changing at the moment...but the cost has been about \$350 each cycle of treatment. And if you compare that against an IVF cycle then there's quite a considerable difference.<sup>30</sup> There are people who have difficulty affording DI.

Sean, who was azoospermic as a result of a missing vas deferens, and his wife Pippa had been offered ICSI as an option but decided that DI was a more 'reliable' alternative. They said:

Pippa: They said they'd have a look at Sean's testes and see if there was any sperm, and it was all going to be quite expensive.

KH: So you looked at the possibility of doing ICSI?

Sean: Yes. But it seemed expensive, intrusive and unreliable.

Pippa: Yes, it seemed unreliable. We could spend quite a lot of money and get nowhere. It wasn't as if Sean had some sperm, say, a thousand, but he had nothing, so we thought it was a bit of a long shot really. We didn't want to go down that path.

Dr C raised the issue of the importance of considering the relative success rates of ICSI and DI when couples were considering the options. He said:

Dr C: When considering the options, you need to look at the outcomes, and by far the most successful option still is donor insemination. And compared to ICSI, where although ICSI might have an

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<sup>30</sup> In June 1998, the new price list for various treatment options through this clinic shows that donor insemination cycles cost \$450. In comparison, a cycle of IVF costs \$4,400 with an additional \$1,500 for ICSI. Thus, a single cycle of ICSI costs \$5900, over 13 times the cost of a DI cycle. See Appendix C for price lists provided by fertility clinics.

excellent chance on a per cycle basis, donor insemination is cumulatively the most successful, because most couples continue on for six to eight cycles. In our programme we have had two women who have achieved a pregnancy on their 32nd cycle. But what we normally do now, is couples who reach say nine or twelve, let's say nine goes at donor insemination, without success, we do offer the IVF programme with donor, or they can convert to ICSI if they have sperm.

According to Dr C, DI was cumulatively a more successful option for achieving assisted conception than ICSI because people could generally afford more cycles.<sup>31</sup>

Several couples who had had a child by DI, had had the opportunity to use ICSI technology which would enable them to have a child that was biologically related to them both. However, as some couples found out in the process of trying to have a second child, female infertility factors, such as reaching a premenopausal stage in their reproductive life cycle, had then intervened so ICSI was no longer a viable alternative. Alice and Peter, who had had a daughter, decided to wait for ICSI technology before trying to conceive another child. They said:

Alice: We had heard ICSI was coming very soon and so we thought that, well, rather than have a donor baby, we will see if we can have one so it's a full biological child for both of us...because that was our first preference.

Peter: Yeah. And we were advised that we were good candidates for it, so, it was worth waiting, but I think Alice probably pushed us more along the ICSI path than I felt it necessary to go initially. I was a little bit concerned that having another child with different biological origins just might make it a bit too complex, you know, in terms of family relationships, and sibling rivalry....

Alice: It was probably about two years after we could have gone back on the DI programme, by the time we came up for ICSI, and the technology was there and we had to go for tests and everything again, and then discovered that my FSH levels were all kind of elevated, which are sort of indications of aging, early aging, or pre-menopausal kind of things happening for me, which meant my fertility has really gone down, and...

Peter: We weren't good candidates anymore.

Being positioned at the cross-roads of the introduction of new reproductive technologies that offered parents their first choice, to both be genetically related to their child, produced a paradoxical situation for Alice and Peter. Like many women who wait to conceive until the time is 'right', Alice found that the right time for her to conceive had passed. This suggests that certain 'natural' conditions, such as the onset of pre-menopause, can impede nature being assisted in other ways. Peter and Alice

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<sup>31</sup> Although cost is a major factor in the number of cycles couples attempt, it is also possible that, because DI is a simple, non-invasive procedure compared to ICSI, more cycles can be tolerated.

had a sense of having missed a critical “window of opportunity” for getting pregnant again by DI while waiting for the arrival of ICSI. Events such as these also reinforce the notion that it may not be possible to write our own life narratives “de novo”: things happen or fail to happen to us (Kirkman, 1999:8).

Peter’s remarks suggest that having had a child by DI can have the effect of making the ‘first choice’ of having a ‘full biological’ child less desirable and even problematic for parents of children conceived by DI. Having lived and accepted an identity as non-biological father of his daughter, Peter was less inclined to pursue an identity of biological parent of another child. He raised the issue of potential rivalry between ‘half-siblings’ were they to pursue ICSI as an option for conceiving a second time. Diane and Chris had considered trying for a second child with ICSI technology but, unlike Peter and Alice, had rejected it. Diane said:

Diane: The biggest thing when it came to having a second child was that ICSI was available and we actually decided not to do that, not for financial reasons, but because we didn't feel the need, eh. It's Chris's ultimate decision, so, you know, he probably could have had a biological child if he wished, but we chose not to, we chose to do the DI again.

KH: So they would be full siblings?<sup>32</sup>

Chris: Mm.

Diane: Yeah. Though not just for that reason, I just couldn't be bothered getting back on...well at that stage...it's quite a joke when you think about it now...we could not be bothered getting on to the whole roller coaster with the infertility thing. As it turned out we did that anyway (she laughs), because it's...you know...because we haven't been able to get pregnant again.

Diane and Chris had rejected ICSI primarily because having had a child by DI with whom they had happily bonded, it seemed less important to have a child who was genetically theirs. However, like Alice, when trying to conceive again, Diane discovered that she had become premenopausal: her oocytes were categorised by fertility specialists as too “old” when she failed to conceive again by DI. As a result, Diane and Chris opted to board yet another “roller coaster” by attempting to have a child using donor eggs and donor sperm. If this were to be successful, Diane and Chris would have a child who was not genetically related to either of them. The lack

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<sup>32</sup> I asked this question because most couples said that once they had conceived a child by DI they preferred to use the gametes of the same donor for a second child so their children would be fully biologically related, rather than half-siblings. This, however, did not appear to be the major concern for Diane and Chris when deciding to conceive a second child.

of a genetic tie did not appear to be an 'issue' for them, but, of course, a biological tie to the child would exist through Diane.

Other couples had rejected ICSI on the basis that they had children who were not genetically/biologically related to both parents, and they did not wish those children to feel "less than" a child who was biologically related to them both. Sarah, who had two adopted children, one foster child and one child conceived by DI, said:

Sarah: That's another question people ask us, now, with ICSI, would we do it? And no. We wouldn't. It's not to do with anything financial. I mean, when Mum first found out about it she said, "Oh, when I win Lotto I'll give you guys some money", and I said, "well don't worry about it." We don't want our kids to feel we had to keep going to get a biological child. If we wanted to have a bigger family, we'd get DI, or possibly adopt again. But we don't want them to ever feel put out that we had to keep going and going. If we had a natural pregnancy, well, okay.... So, we would never do that. And I've seen ICSI throw couples into absolute chaos again. You know, because you deal with all your male infertility. You remedy the problem, or you don't remedy the problem. Some couples I know have just come to terms with just living childfree. Now all of a sudden ICSI's come and it's just reared all this stuff up all over again, and they were in a good place, you know?

Sarah's desire not to undermine the value of the children they already had, and the rejection of ICSI on this basis, nonetheless reproduces the notion of the primacy of the biological tie. Sarah's comment about her mother's offer to help them pay for ICSI if she won the lottery raises the spectre of possible social/family pressure on infertile couples to avail themselves of reproductive technologies that enable them to forge genetic links with their offspring (and therefore to the grandparent) (Ragone and Willis, 2000). Sarah also raised the issue that a new technology such as ICSI, which for the first time enables men with low sperm counts to become biological fathers, has obvious appeal but, like all 'pathways' to parenthood, presents challenges as well as possibilities.

A nurse working in the donor programme at a fertility clinic commented on the dilemmas that emerge for couples choosing between DI and ICSI. She said:

Nurse A: Demand for DI is changing now with new procedures for male factor infertility, whereby they can actually get into the testes and extract some sperm. Some couples have to weigh up the cost, and for some couples it's not viable because of the cost. But also then they have the chance to have their own children, but again it may depend on what the husband's condition is as to whether he passes on the condition to the child, even with ICSI. They may produce a male child who has a similar male factor problem, and again we're not going to know this until the child's an adult. And there have been families caught in the dilemma where they've had a DI child. Now ICSI's available, what do they do? Do they opt for ICSI, or opt for

another DI child using the same donor? So that causes dilemmas for some couples too. It's when we're at the crossroads of new technology.

The advent of new technologies such as ICSI, which create new pathways to biological parenthood, also raises the issue of the shifting of 'goal posts' for couples attempting to conceive, and the difficulty of deciding *not* to pursue the options that might lead to biological parenthood. Although no couples mentioned it, Nurse A raised one of the problems associated with ICSI: the possibility of men passing on sex chromosome abnormalities that cause male factor infertility to any male children they might conceive using their own sperm (Fertility Associates, 1998:80). This could constitute another valid reason for rejecting ICSI and favouring DI, though it appears that many couples are willing to accept this 'risk' in the bid to have their 'own' genetic/biological child. Another nurse working in a DI programme spoke of the attraction for couples of trying to conceive by ICSI:

Nurse B: One couple have two donor children and have come for...and that was a known donor...it wasn't an anonymous donor, it was a known donor. And they have had one or two ICSI cycles. They felt that it wouldn't matter if it didn't work because they felt they'd completed their family. It didn't really worry them, but it's interesting. I'd be interested to know just what motivates them to sort of keep going. Whether it is the fact that they think they might be able to perhaps use their own gametes, I don't know. But it really quite fascinates me, you know. For a start, this one particular couple, they were just having one. Well they're coming back for a second, you know, so that their goal has altered from being just one go to hoping to achieve a pregnancy.

In the case Nurse B refers to, the chance to have a full biological child appeared to be irresistible for the couple. However, it is also possible that they wanted more children and were able to afford ICSI. Nonetheless, this raises the issue of the importance of biological parenthood to some people.<sup>33</sup> It also raises the question of whether, in what Strathern (1992b:35-36) refers to as our Enterprise Culture, it is regarded as irresponsible *not* to avail oneself of all the technologies available. Alice and Peter talked about the difficulty of stopping fertility treatment in the face of expanding possibilities of becoming pregnant and fulfilling the desire to parent not just one, but hopefully more than one child. They said:

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<sup>33</sup> Williams (1990) examined adoptive mothers' motivations to attain biological motherhood when they were already 'social' mothers. She found that women were motivated by factors such as being able to experience biological motherhood, "to give my husband a child", and being able to have a two-child family. One woman was motivated by the feeling that one should be able to look back in the future and say that one did one's best to achieve biological parenthood. It is possible that similar motivations exist for couples who try to conceive by ICSI.



Alice: It's a very hard thing too because you know technology is going to come along, and you know, as soon as you give up, a few years down the track they'll be able to do something. So it is really hard.

Peter: We've sort of been encouraged by Dr A too, because he will never say anything for sure. And he always, there's always like enough margin there for kind of something unpredictable to happen. So you never really feel that you can say for sure that you're out of the running. And you've really got to come to...it's a personal decision to actually pull out rather than necessarily being out of the running I think. There's some possibility...there is some hope, but, I've been a bit sort of run down by raised expectations and then disappointment, and it's sort of been quite a progressive thing where the stakes get higher and the disappointment gets greater, so...(he chuckles).

The difficulties involved with making the decision that one is “out of the running” highlights the contingent aspects of achieving pregnancy and the birth of a child. In the words of a fertility specialist, “pregnancy is a chance event”.<sup>34</sup> While on one level, advances in reproductive medicine appear to have moved fertility and infertility into “the realm of the controllable” (Ragone and Willis, 2000:308), much about what actually leads to pregnancy and the birth of a child is unknown and controllable only up to a point. Professor Hutton has argued that assisting conception is not an exact science: much of reproductive medicine, he said, lies in the realm of “the subjective”.<sup>35</sup> In other words, while reproductive technologies are designed to assist natural processes, this is only in the realm of what is “natural” anyway. Thus, he emphasised that because of the complexities surrounding the highly contingent events of conception, pregnancy and the birth of a baby, people should not look to medical ‘treatments’ as improving the chances above what happens in nature, which yields a 20-25% pregnancy rate per menstrual cycle.

Talk of “choices” and “chances” in fertility treatment suggests that embarking on a treatment cycle to achieve assisted conception is akin to gambling – though ‘loaded’ gambling in the sense that insemination is attempted when the chance of success is greatest. Statistics of success rates<sup>36</sup> represent the odds but, even though they may be low, the chance of success always looms as a real possibility. As Peter pointed out,

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<sup>34</sup> Professor John Hutton, “Choices and Chances”, address to the New Zealand Infertility Society Symposium, Friday August 11, 2000, Christchurch, New Zealand.

<sup>35</sup> Professor Hutton’s use of the word “subjective” here implies that reproductive medicine is not an exact science like in some of the physical sciences where outcomes can be more readily controlled and predicted. This explanation is perhaps used as a defense for not achieving high rates of pregnancy through assisted reproduction, which some people might expect. He suggests that given that high success rates do not occur in the realm of ‘natural’ conception, it is not realistic to expect ‘perfect’ results through technological assistance.

<sup>36</sup> DI success rates are discussed in more detail in Chapter Seven.

expectations can be raised and the disappointment resulting from the failure to beat the odds can accumulate in the process of experiencing repeated cycles of optimism followed by the disappointment of failure. But the odds of achieving success remain, adding fuel to the optimism that the next cycle might yield the desired result. Hence, the perennial difficulty of what is commonly referred to as “getting off the infertility treadmill” (Thorpe, 1994).

### **Considering a known donor**

All couples in this study, except one lesbian couple, were recipients of sperm from an anonymous, rather than a known, donor. Several couples, however, had initially considered asking a brother of the infertile male to be their donor, thereby indirectly creating a biological link between the father and child. In relation to this choice, a nurse working in a DI programme said:

Nurse A: Some people feel they'd like to know who the donor is, and they have perhaps asked the husband's brother, if they felt comfortable to ask him, or perhaps in the family environment, the family have known of the couple's situation, and perhaps the brother has offered. So with that arising, we have to screen them the same way, and again, they have to have counselling - the donor and his wife, the recipient couple, um, separate counselling sessions and then one together to go through all the different issues that may arise.

KH: So, if there is a known donor, is it usually a brother? What about friends?

Nurse A: We have had a situation where it was the wife's sister's husband. It's usually a brother. I can't think if there've been any friends. It has usually been a relative.

Very few couples who had gone through this donor programme had used a known donor. Dr A said:

Dr A: We've probably used known donors, oh, for a bit over eight years.

KH: About what percentage would use a known donor?

Dr A: Oh, not very many. It's not very many. And they're probably usually the more outgoing, astute sort of people. I'm not sure whether it's intelligence, or...it does seem to be people who have a more sort of open view of the world.

Sarah and Tim, a couple who had one adopted son when they were considering having DI, had asked Tim's brother to be a donor. Tim said:

Tim: We did initially talk about maybe asking my brother, and that fell flat on its face.

KH: Did you actually ask him?

Tim: Yep, and it was a bit of a big ask. But I just thought, hey well, we're going to go through it and it's going to be such a long waiting span. We wanted to have a little sibling for Rob. As it was, we just poured everything into it, like we were hanging out for kids. So, um, we mentioned it to my brother. He was actually reasonably keen, and then his wife wasn't keen on it at all. And we didn't want to get...it's hard, but we just wanted to get things going, you know, and it was probably a bit, hey, why not? I mean, if he wants to and he's happy, I mean, he's got his family, he's not going any further. That was before he had a vasectomy and stuff, so, and ah, she wasn't that keen on it. But it probably worked out okay in the end. It probably was better, because I can imagine, with his wife, there'd be all this comparison... it might be a little bit close to home. But I mean, at the time I thought, well, once we've made our decision we were comfortable with it. Sarah got a little bit upset about that, but I said "No. We've taken a long time to work through this, and that's *their* choice. You've got to respect that."

While Tim had actually asked his brother, but his sister-in-law vetoed the proposition, others who had considered asking a brother to be a donor had discounted the possibility even before raising the issue. Peter and Alice said:

Alice: When we had the interview with the social worker that you had to have before you go onto DI, she mentioned other possibilities, like using a known donor. We actually sort of briefly considered one of your brothers didn't we, then we thought no. It's just...

Peter: It's just too messy.

Alice: It was just...it felt like it would have been more awkward for Peter in a sense, and for us in terms of family relationships than having an anonymous donor.

Peter: Even if a family member was able to kind of *not* interfere in the upbringing of a child, or be quite detached from the whole arrangement, you'd always feel that you were being kind of scrutinised, or your performance was being assessed in some way, because they would have a certain amount of ownership in the child as well. And so, although initially that seemed like quite an attractive option, we ruled it out and never even talked to him about it actually.

Peter and Alice anticipated that a brother with a genetic connection to their child would position himself as having some form of 'investment' in their child, and perhaps evaluate their performance as parents. Similarly, Tim was concerned that his sister-in-law would compare their child with her own. In their New Zealand study of couples who had used personal donors, Adair and Purdie (1996:2560) found that some recipients had chosen a friend as a donor to avoid such complications. In some cases in which a brother was a donor, the relationship between the two families had deteriorated, which was related to the donor's partner not being involved in the decision to donate. This indicates the difficulty of divorcing the concept of 'gamete donor' from that of 'father' and the social expectations and connotations that inhere in the identity of the latter.

Jeremy and Christine, family members of Richard and Belinda, said that there had been some discussion in their wider family about the possibility of Jeremy, who was Richard's twin brother, being a donor for Richard and Belinda. Jeremy and Christine were uncomfortable with this idea. They said:

Jeremy: We certainly never offered and they never asked. No, we never talked about it at all.

KH: What would have been your response if they'd asked?

Jeremy: No. No.

Christine: Yeah we decided we'd have to say no. We decided that...

Jeremy: No. We didn't think it was appropriate. I don't think we...um, no I don't think I could cope with it, and I don't think Christine could either. No we weren't prepared to do that because...

Christine: We decided it would just be too much potential for it all to go wrong. Much as it was a nice idea, and because the boys were twins I could see how good it could be, but I could also see it had the potential to go completely wrong and completely ruin the family, and so we decided that...and I personally myself, I didn't think that I'd cope with seeing another child that I knew was Jeremy's and not mine, so...

The potential difficulties associated with gamete donation within extended families raises questions about the social meaning of gametes. Novaes (1989:641) argues that donation is not just a physical act: semen, oocytes, embryo, pregnancy and children are strongly charged with meaning in most, if not all, cultures and exchanges of these substances, roles or persons are admitted only in socially prescribed relationships. While not explicitly stated, Jeremy and Christine's discomfort at the idea of his donating semen to enable Belinda to conceive may be related to ideas about monogamy, and to the desire to avoid a situation that might imply an extra-marital relationship between Jeremy and his sister-in-law.

The discomfort felt at the prospect of using a sibling as a donor thus raises issues about 'attachment' to gametes, and the different meanings attributed to sperm donation and egg donation.<sup>37</sup> Research carried out in the United States by Sauer et al (1988) compared the attitudes of couples on ovum donation programmes with those on sperm donation programmes. The study found that most patients using donated eggs had considered using a sister as a donor and 61% had secured an agreement. In contrast, few (11%) of the couples undergoing DI preferred using a brother as their donor and none had asked one to participate. These findings may be attributed to the

different social meanings attached to sperm and egg donation explored by Haimes (1993a). In her analysis of the Warnock Report (1984), she found that semen donation was seen as ‘deviant’ sexually (associated with masturbation, adultery, and illegitimacy) and motivations to donate as somewhat suspect. This raises the question whether, in the case of using a brother as a sperm donor, others might assume adultery. If, for example, a familiar and intimate person, such as a brother/brother-in-law, is to ‘give’ sperm then it could be construed that he might equally have done so ‘naturally’, and who would know he had not? In contrast, egg donation was conceptualised as familial, clinical and asexual, and the donors altruistic. As a result of these dominant cultural conceptualisations, it appears that couples are generally more comfortable asking a sister, rather than a brother, to donate their gametes.

Instead of asking a sibling, lesbian parents, Sophie and Ria, asked a gay male friend to be their donor. When asked if they had considered conceiving through a DI programme, they said:

Sophie: I haven’t really heard much about it. I wasn’t aware that it was open for lesbian couples or anything like that. It was something that we just never considered.

Ria: I don’t think I would consider trying to get pregnant through a clinical insemination, unless I tried all other avenues and it didn’t work for me, and I was desperate, maybe I would.

Sophie: It just seems so clinical, for one thing. And expensive. Whereas for us, it was totally free.

KH: And you were just able to ask a friend [to be a donor].

Sophie: I know, we were very lucky, we were so lucky to know Derek really. We’ve often thought that it would have been different in Sydney. I think it’s important for us to have someone close that we know, so that he can be part of the child’s life.

Sophie and Ria wanted to acquire a male ‘parent’ who would be part of their child’s life. In contrast to the situation for heterosexual couples, where both a genetic and a social male parent exist, to them, their male donor was unproblematically the child’s ‘father’ and not construed as in competition with the other female parent.

Unlike Sophie and Ria, Petra and Jennifer, another lesbian couple, had opted to use an anonymous donor through a DI programme to conceive a child. However, they had decided to follow this path after originally considering other options. They said:

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<sup>37</sup> These issues are discussed in more detail in Chapter Ten.

Petra: I don't think we would originally have assumed we were going for donor insemination. I think when we talked about [having children], which was in quite abstract terms when we first met, we'd always assumed that we would. Well, my progression was, either go straight, probably wanted children more than I thought I needed a lesbian relationship. Then, have a child with someone who we knew, and then thinking about the mechanics of that, it was, so how would three people parent? It's quite hard to keep a two-person relationship going, but a three or four person relationship, especially around a little person, would be really chaotic. So that's when we began to move to a sort of...it would probably be easier if it were someone who was out of the picture until Olivia's older.

Jennifer: The whole system in England is different, because [donors remain anonymous], and because of that, maybe if we'd stayed in England we may have made a different choice. But because we liked the programme here and liked the fact that it was an [identifiable] donor later in Olivia's life, we felt quite comfortable with going through with that... If we had gone for somebody, a known donor, a friend basically, in the UK, then we would have started a whole different set of negotiations, in terms of asking what kind of contact they wanted to have with any offspring and all of those things. It would have been a totally different question. Like taking a different road...we chose a different road.

In choosing to have a child through an anonymous donor programme that recruited potentially identifiable donors, Jennifer and Petra were reconciling their desire to be the only parents of their child, and the recognition of their child's 'right' to identify the donor when she was older. Had they chosen a friend to be a donor, they anticipated having to undertake a different set of negotiations.

### **Choosing donor insemination**

For many couples with male infertility, DI presented as the only viable option if they wanted to have children. Peter and Alice said:

Peter: Well, it was certainly not the best option, from my point of view.

Alice: Compared to normal.

Peter: Compared to normal...being a biological parent. I didn't have any reservations about going ahead with it, but it was difficult to know, you know, you can't know how you're going to feel. So I guess I was always kind of a little bit reserved about how I might sort of feel, or react, or whatever. There's just no way of knowing until you're faced with the situation. And so, it just seemed like the best choice at the time, so we sort of went for it.

Before their daughter was born, Peter was somewhat concerned about how he might feel about a child who was not genetically connected to him.<sup>38</sup> Peter's parents expressed some disappointment, on Peter's behalf, that he could not become a

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<sup>38</sup> See Chapter Eleven for a discussion about fatherhood after DI.

biological parent. When asked about their reactions to Peter and Alice having a child by DI, they said:

Marjorie: We were delighted regardless of the situation. You know, we were very happy about it. It didn't affect us at all really. We were quite happy about it.

Jim: It's sad I think that Peter...I think Peter was the problem...that they weren't able to have a child themselves. That was a bit disappointing probably, inwardly, without mentioning it.

Marjorie: For Peter's sake I think.

Jim: Yeah, yeah sure. It didn't worry us, but we just felt that there was...Peter would have felt disappointed at that stage. Guessing his attitude, but he was quite happy to go through the programme...you know it was an alternative to nothing.

Like Peter, Joe had concerns about how he would react to children who were not genetically related to him. He and his wife Ella said:

Joe: Well the only concerns I had was that I was just really unsure how I would react to it, not being my, my genes, or whatever you like to call it. I was a little unsure.

KH: You mean about bonding with the child?

Joe: Yeah. If things get really tough do I scream at them and say, "you're not my bloody kids. Get out of here!" sort of thing, or what? I mean you still say that, but...(he laughs).

Ella: No, no. We discussed that and I said to Joe you've got to be careful of a lot of things you say in ways that you don't really mean.

Joe: Things all of a sudden take on a new meaning.

Joe was aware that he could not easily 'disown' his DI children, if, for example, he was annoyed with them. This illustrates Ragone and Willis's (2000:317) contention that in Euro-American kinship ideology, while social ties can be severed, "the blood relationship cannot be lost", nor can one have an ex-blood relative.

Not all couples were in complete agreement about pursuing DI. Meredith, whose husband Karl declined to participate in this research, said that Karl was initially reluctant to have a child by DI. But, because of her age, Meredith felt they needed to act quickly. She said:

Meredith: Finding out that he was infertile was a real shock to him, I think, because it's a male sort of ego thing too, isn't it? It's part of being a man. So, and it all happened quite quickly. We found out about that and because of my age, you see, being older, we needed to sort of get onto things straight away. We didn't have time to just think about it, because by that time I just really, really wanted to have a child. I think it's something to do too with once you know

you can't have something, the more determined you are, aren't you? I mean, I know I shouldn't put it like that...but... And we'd bought a big house with four bedrooms...and we were all ready to have children. Then all of a sudden, when you're told you can't, it gives you a bit of a setback, doesn't it?

This suggests that Meredith drove the decision to pursue DI while her husband was still coming to terms with his infertility. The situation raises the issue of the difficulty for some couples of coming to a mutual decision to go ahead with fertility treatment, because of their differing responses to their infertility, and attitudes towards seeking treatment (Gillett, Daniels and Herbison, 1996). It also reinforces a point made earlier about the need to deal with infertility before trying to deal with the issues of DI. Meredith raised a point often associated with infertility, that the loss of the choice to have a child leads to a feeling of a loss of control over one's life (Noble, 1987). Like Meredith and Karl, Mike and Caroline decided quickly to try to conceive by DI but, unlike Meredith and Karl, they both felt comfortable with the prospect of using donor sperm. Mike and Caroline said:

Mike: It was the best option. I had never thought about *not* having children, so the prospect of me or us not having children was quite daunting, and that step of accepting someone else's sperm was not very difficult for me.

Caroline: I think that if one of us had had a really strong view against it, then I think the other one would have respected that and probably we might have gone another track. But, as it was, we both decided that this was right.

While Mike accepted that they needed to use somebody else's sperm to achieve parenthood, Caroline was initially "revolted" by the idea of DI. She said:

Caroline: ...when [the doctor] mentioned it, I thought, no I couldn't possibly do that. It absolutely revolted me. I just couldn't bear...you know, fancy putting somebody else's sperm inside you...it did, it just revolted me. I just thought it was revolting. And Mike was the one who thought, oh maybe it's not a bad idea.

As well as feeling physically ill at the prospect of being inseminated, some women also felt that by being inseminated with another man's sperm, they were "cheating" on their husbands. Pippa said:

Pippa: I felt a bit guilty about it initially, about wanting to do it.

KH: Why?

Pippa: I don't know. I felt that I cheated on Sean.



KH: You mean a bit like...

Pippa: Adultery. But then I thought it's either that or we have an adoption, and at least if we had a baby through donor insemination it would be related genetically to one of us. And I wanted to be pregnant, and breast feed and all of that, if we could.

KH: So, did you think that Pippa should have a chance to do that?

Sean: Yes.

Both Pippa and Sean drew on a discourse about the importance of women being able to experience biological motherhood as a reason for choosing to have a child by DI. For Pippa, this intersected with discourses about adultery and illegitimacy.

In contrast to the negative or ambivalent feelings some individuals encountered when choosing DI, Diane, the mother of a DI child, said:

Diane: We've read that some people think it's like adultery and all this sort of thing, and I mean I just can't imagine. That's such an extreme view. If you felt like that, you shouldn't do it basically. I've read a lot of information on the whole infertility field: DI and all the rest of it. Just things I've read in books I haven't been able to relate to at all. I've always been quite matter-of-fact about the whole issue, and it's almost like you're reading something completely foreign.

Diane and Chris were positive about their entire experience of having a child by DI and wanted to share this perspective with others as a means of helping them through the process in the future. Another couple, Allan and Sandra, were also positive about the option of being able to use donor gametes. They drew on discourses about the exciting possibilities offered by science and medicine to remedy bodily malfunction. Allan said:

Allan: In twenty years time, people in our situation, with cloning technology, you know, they may be able to take cells, not necessarily from the testes, just any part of the body, take out the nucleus, and clone, and then you can pass on your DNA genetic material. But to me, you're part of the world. The whole world's your family to some extent. Everyone in the world, no matter what colour, is part of the human race. I suppose, after having two families and sort of extended families, you know, with Mum having a child before she was married and that sort of thing, you know, you perhaps don't build a pedestal around the notion of heredity - having to have a male heir and all that sort of thing. You realise that those sorts of things are really pretty superficial.

Allan appeared philosophical about using another man's sperm to have children. By conceptualising the human race as one big family he appeared to minimise individual 'ownership' of gametes, and the centrality of biological relatedness in Western

kinship ideology. Thus, he emphasised 'family' as a social rather than a genetic phenomenon.

Liberal views about the sharing of reproductive material across families stand in direct contrast to some religious views on the use of third party gametes in assisted reproduction. The Roman Catholic Church's position on DI is that it is morally wrong because it interferes with the sanctity of marriage (Lauritzen, 1993). It is therefore significant that about one third of participants in this study who had children by DI were brought up in Catholic families. Many were critical of the Catholic Church's position on reproductive matters, maintained that its stance was irrelevant in contemporary society, and argued that the Church's views had little influence on their decision to have children by DI. Mike, the father of two daughters conceived by DI, said:

Mike: The Catholic Church is quite strong on their beliefs about both preventing childbirth and assisting childbirth. I think the people at the top of the church have done a lot of things that are not logical in today's world. I think they've lost the plot, so I find it very hard to take that religion very seriously. I'm a little sceptical about religion. I'm aware of international...I've spent some time in Bosnia and I know what people have done in the name of religion, so it doesn't add up. So, I mean, when you get that, and you get the Church stating that you can't do things like assisted reproduction, then what they're doing is effectively saying that we had no right to do what we did, and I believe what we did was appropriate, so...Their policy is an interpretation of something that was translated a few hundred or a thousand years ago, and someone's subjected it to an interpretation.

Mike's position, and the views of other parents who identified as non-practising Catholics, illustrates Shilling's argument about the desacrilisation of social life in modernity (1993:2). He argues that in high modernity, the power of religious authorities to define and regulate bodies has diminished, while the power of nation states in general, and the medical profession in particular, to exert control over bodies has increased. While science has increasing control over our bodies, Shilling maintains, "it has failed to replace religious certainties with scientific certainties of the same order"(1993:2). As a result, he contends, science has failed to provide us with values to guide our lives, leading to an increasing privatisation of meaning in modernity, which leaves people alone to establish and maintain values to make sense of their own lives.

Despite repudiating the Church's teachings on assisted reproduction, many parents in the study, who were raised as Catholics, retained Catholicism as a part of their identity. Thus, it might be argued that Catholicism is part of a broad cultural identity, as suggested by the adage, "once a Catholic always a Catholic". It also could be argued that conception and birth are considered 'sacred' events in Euro-American culture, whether or not people 'practise' a particular religion. While claiming that their faith was somewhat "shaky", Simon and Clare sent their DI daughter to a Catholic School. They said:

Clare: It's my biggest fear actually, that she's going to come up with a question in a Catholic school.

Simon: A morning story.

Clare: Depending on the teacher, I might have to forewarn them.

Another mother of two children conceived by DI said:

Annie: Well, I guess I have been brought up a very, very strict Catholic, and I knew that my religious background would not agree with this. That was something that was in the back of my mind but, having said that, I'm not a religious person, so I didn't take too much notice of that, but it was always in the back of my mind.

While Annie positioned herself as "not religious" she was conscious of going against some of the values espoused by her upbringing. Similarly, a Catholic upbringing appeared to have influenced the views of Steve, the father of twins conceived by DI, who was concerned about what he perceived as a stigma attached to having children by DI.<sup>39</sup> Although he maintained that his Catholic upbringing was "out of his system", he nonetheless drew on Catholic discourses to explain his position. He said:

Steve: [DI is] a sort of thing that some people may react adversely to, and think it was the wrong thing to do, and you know that some people around have got that opinion, and it's out there in the community. People sail along until something pops up that's controversial. Then, they immediately show their true colours, you know, run the battle flags up and all that sort of thing. It's just like when I first got married, and I got married in the Salvation Army, and I was brought up a Catholic. I mean to say, immediately the nuns found out about it, I was, as you might say, excommunicated because there was a stigma placed on it, you know. I don't know if you've found that in society today...that it is there.

## Conclusion

This chapter has focussed on the critical moments, contingencies and decision-making processes that constitute the ‘experience’ of infertility and alternative strategies for achieving parenthood. Analysis of the narratives of couples and their family members indicates the importance attributed to the biological/genetic connection between parents and children. Couples draw on this dominant discourse to construct having a child ‘naturally’ as their ‘first choice’ and DI as a ‘second best’ option that facilitated a genetic/biological connection to the mother, if not the father, of the child. Given the significance attached to biological connections within families, the decision to conceive to DI after a diagnosis of male infertility was fraught with ambivalence and complexity for both couples and their kin. The chapter makes a unique contribution to this field by indicating the significance for couples of familial responses to their infertility and the ways in which a couple’s difficulties in conceiving are embedded in wider kin relations.

Analysis of couples’ narratives illustrated that the discovery of infertility disrupted couples’ narrative identities and created the need to examine their individual and shared identities and their goal to become parents. Similarly, analysis of the talk of kin of infertile males indicated that they too had to re-evaluate their identities in connection with developing relationships with a child or children not genetically related to them. The chapter therefore highlights that infertility and the conception of a child using donor sperm has implications not only for parent/child relationships, but also for relationships between grandparents and grandchildren, aunts, uncles and nephews and nieces. Illustrating this point, many infertile men and their extended family members anticipated that their relationship with a child who was not genetically related to them or their ‘side’ of the family would be qualitatively different from a relationship involving genetic ties.

The chapter raises the issues of infertility as both a private trouble and a public issue. It highlights particularly men’s reactions to infertility, their ways of coping with the emotional issues associated with this diagnosis and the implications for couples’ relationships. It also indicates that a diagnosis of male infertility has implications for

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<sup>39</sup> The issues of stigma and marginalisation were seldom overtly raised by participants and are discussed in more detail in Chapter Eight in connection with issues of secrecy and disclosure.

wider kin, most who had no first-hand experience of infertility and felt unable to provide adequate support because they lacked knowledge about it and alternatives for parenthood. While many couples grieved alone, others sought support at some time from counsellors, family members, friends and infertility societies. The difficulty of both getting and giving support from others raised the issue of the need for appropriate systems of support for couples conceiving by DI and their wider family networks. Some couples had attended infertility society meetings but did not feel supported by those in the same predicament as their own. Analysis of the interview material shows that while they may have shared their ‘troubles’ with others, ultimately couples had to confront the issues themselves and choose their own pathways to becoming parents.

Analysis of couples’ decision-making processes in relation to strategies for parenthood revealed a number of complexities and paradoxes. Most couples rejected adoption for a variety of reasons. DI, on the other hand, was favoured because it offered the biological connection to the mother, if not the father, and a chance for the parents to experience together the pregnancy and birth of a child. Contradicting this stance, some family members of infertile males had initially preferred adoption for the infertile couple. They believed that the lack of a genetic/biological connection between and father and child in DI placed the father at a disadvantage in relation to the mother, in terms of bonding with the child, or if the marriage was to end. Thus, while couples emphasised the significance of the existence of a biogenetic connection between at least one of them and the child, extended kin of infertile men stressed the asymmetry between the parents. This again, illustrated the strength of the discourse of the primacy of biogenetic relatedness and the claims that are perceived to ‘naturally’ inhere in these ties.

The arrival of ICSI as a strategy for parenthood created dilemmas and paradoxical situations for some couples considering having more children. Whereas it provided an opportunity for them to have their ‘first choice’ of shared biological parenthood, this option appeared more problematic after having had a child conceived by DI. This indicated that while a biogenetic connection to both parents is perceived as ‘ideal’, in reality, after experiencing other forms of parent/child connectedness, the genetic tie can be perceived as less significant than the social bonds that are later formed. Some

parents argued that it would not be in the best interests of their existing children because a sibling with a biological connection to both parents might be perceived as 'preferred'. Others were less concerned about the lack of a 'full' biological connection with their child after strong social bonds were formed, or took a more instrumental approach and rejected ICSI on the basis that it was expensive and potentially less successful than DI.

The chapter raised issues relating to the use of family members as sperm donors, indicating that the choice of a brother of the infertile male as a sperm donor was problematic. This raised questions about the social meanings of sperm donation and the cultural connotations relating to sexuality and adultery and the implications of these for family relations. Most had rejected asking brothers to be donors on the basis that it could cause undue complications for family relations. These concerns were connected to possible claims the brother and his wife might have to the child, and also 'claims' the wife might have to her husband's sperm. For most of these couples, using sperm from an anonymous donor was regarded as easier and potentially less complicated. One lesbian couple had chosen a known donor, a gay male friend to be the 'father' in their child's life. Another lesbian couple, however, chose an anonymous donor for the same reasons that heterosexual couples chose an anonymous donor: so they could be the sole parents of their children.

This chapter therefore highlights that the decision to procreate using the sperm of an unknown third party is fraught with ambiguity and complexity. This was chiefly because DI challenges cultural norms about 'ideal' or 'proper' ways of forming families, the primacy of the biogenetic connection between parent and child and social and cultural meanings attached to gametes. The issues raised have implications for policy and practice in DI programmes and also highlight the issues that might arise for couples and their families after the birth of a child conceived by DI. For most couples, while not their first choice, DI appeared to be most viable means of achieving parenthood. Many parents and their extended kin, however, were initially ambivalent about choosing DI. Despite some of the difficulties encountered in choosing this means of conception, as active agents and decision-makers, these couples were nonetheless generally able to justify to themselves their choice of DI as a strategy to achieve the much-desired and socially-sanctioned goal of parenthood.

## Chapter Five

### Anonymous Gifts, Constrained Choices and Competing Rights in Donor Insemination Programmes

It is the gift of life. It's a special gift when someone gives a part of themselves, whether it be their heart, or their eyes or whatever. Anybody who can give somebody life like that must be a special person. - *Helen, mother of two sons conceived by donor insemination*

#### Introduction

This chapter examines the discursive strategies that are used to recruit donors and establish sperm 'banks' by constructing semen donation as an altruistic 'gift of life'. It also explores how relationships between the various social actors in DI programmes are initiated. Central to the analysis are issues of trust, choice, control and rights. General understandings about how DI programmes operate are analysed in their local context. The discursive and relational strategies employed by medical professionals are a major focus of attention, particularly the way that they act as brokers of sperm and intermediaries between sperm donors and recipients. The chapter examines the processes involved in screening donors, maintaining donor records and donor anonymity, linking donors and recipients, and maintaining contact between intermediaries and donors, in light of the possibility that, in the future, individuals conceived through DI may wish to make contact with donors through fertility clinics. The text thus reveals the dynamics of a set of networked relationships which centres on the act of donor insemination.

#### The establishment of donor insemination programmes

The use of donor semen in 'instrumental' insemination, as a medical strategy to address the problem of male infertility, dates back to the eighteenth century (Bateman Novaes, 1998).<sup>1</sup> Donor insemination traditionally has been viewed as an unorthodox and, for some, a morally suspect medical procedure used for the purpose of helping infertile couples conceive and form a family (Bateman Novaes, 1998:110). Bateman Novaes argues that the social, legal and moral objections to DI led to secrecy and

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<sup>1</sup> For a more detailed discussion about the history of DI and how it came to be constructed as a medical 'treatment' for male infertility, see Bateman Novaes (1998:107-110).

anonymity becoming the main organising principles of the practice. Partly because of the moral and legal questions surrounding it, according to health professionals, DI in New Zealand was often practised in an *ad hoc* manner with no formal structure or record-keeping procedures in place.<sup>2</sup> These informal practices, often carried out by general practitioners, also reflect the low status afforded the treatment of infertility in the medical hierarchy. The introduction of more ‘hi-tech’ procedures such as in vitro fertilisation and embryo transfer provides gynaecologists with an exciting and high-status area of research, and a technically more complex practice (Wacjman, 1994:167).

In the 1970s and early 1980s, New Zealand doctors working within university research-related units located in public hospitals practised DI as a ‘side-line’ to their other work in gynaecology and obstetrics. According to Ken Daniels, a researcher in this field, the development of a DI programme in Christchurch, New Zealand, was partly in response to requests for DI from the Spinal Injuries Unit at Burwood Hospital. According to health professionals interviewed for this research, more formally established DI programmes with record-keeping procedures were established in the 1980s. Some of the operational difficulties were addressed when issues relating to the legal status of the donor were clarified through the Status of Children Amendment Act, 1987.<sup>3</sup> The director of a South Island fertility clinic was involved in the establishment of a DI programme in the late 1980s. He said:

Dr A: It was a clinic set up for couples with male infertility... at that point we were treating maybe more or less severe sperm defects than we would now, because we have other ways of dealing with it. I mean usually the men had at least moderate oligospermia and usually severe, or azoospermia. And even at that point, upwards of about 10 or 15% of the men had had vasectomies and failed reversals. So the programme was actually very successful... very good sperm, good quality frozen semen, a lot of pregnancies. And it ran reasonably well. I went overseas... and it worked at a slightly lower key during that time. And then I came back and about that time I was just getting involved with IVF.

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<sup>2</sup> As an example of the *ad hoc*, secretive and informal way in which DI was often practised, a retired General Practitioner interviewed for this research had, at least on two occasions in the 1960s, used his own semen to inseminate a woman patient whose husband was sterile. The doctor claimed to have gained ethical approval from within the hospital system before performing the inseminations. He had asked a close friend to be the donor, but, unable to enlist his help, had used his own semen in the insemination. The woman was not informed of the donor’s identity and the doctor was uncertain as to whether any records remained about the procedure having taken place. Daniels (1998b:77-78) reports a similar case occurring in New Zealand in the late 1950s.

<sup>3</sup> The Status of Children Amendment Act, 1987 recognises the consenting partner of the woman who is inseminated as the legal father of the DI child. Clause 5, 2(b) of the Act states: “the man who produced the semen used in the procedure shall not have the rights and liabilities of a father of any child of the pregnancy, either born or unborn, unless at any time the man becomes the husband of the woman”.



Dr A was a key actor in the setting up of a DI programme which also enlisted the services of a nurse and a scientist. He highlighted the pivotal roles of cryopreservation techniques and of sperm as actors<sup>4</sup> in the DI network. Thus, he revealed the significance of non-human as well as human actors in the DI network. According to actor-network theorists, such as Law, the social is “*nothing other than a patterned network of heterogeneous materials*” (1992:381, original emphasis). This view suggests that social networks are composed, not only of people, but also of machines, animals, texts, money, architectures, and so on. In sum, according to actor-network theorists, the social is not simply human; it is all these other materials as well.<sup>5</sup>

The establishment of DI programmes was facilitated by the development of cryopreservation, the ability to store and freeze semen in liquid nitrogen, in ‘banks’, for later use (Bateman Novaes, 1998).<sup>6</sup> According to Dr A, sperm freezing and banking began to be used in New Zealand in the early 1980s. This procedure meant that for the first time the provision of semen and the insemination process could be separated in space and time (Bateman Novaes, 1998:111). Prior to that, fresh semen was used which meant that donors and recipients had to be brought together in the same place at more or less the same time, although they never met. The ability to store frozen semen has led to the development of new institutional structures and complex networks of participants involved in the preparation, storage and distribution of frozen semen (Bateman Novaes, 1998:111). It has also enabled the quarantining of semen which became an important medical imperative after the discovery of AIDS in the

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<sup>4</sup> This relates to ideas posited by actor-network theorists about the significance of non-human as well as human actors in networks of social relations. Although actor-network theory (ANT) is introduced here, it is not *used* in this chapter. I draw on its descriptive and illustrative qualities rather than its analytic focus.

<sup>5</sup> Actor-network theory offers an analytical stance (rather than an ethical position) that is relational and process-oriented, treating agents, organisations and devices as interactive effects (Law, 1992:389). Rather than focusing on the ‘social impact’ of medical technology, ANT reconceptualises the technology-society relationship by examining how they are mutually constitutive, and providing a way of understanding technologies and devices as “participating in and performing social relations alongside human actors” (Prout, 1996:202-203).

<sup>6</sup> Bateman Novaes (1998:111) describes the semen bank as a “metallic container in which straws, containing semen prepared with a cryoprotective medium, are kept frozen in liquid nitrogen (at about -191C)”. Although technically possible as early as 1949, cryopreservation of semen was for some time restricted to the cattle industry. Bateman Novaes (1998:112) claims that banking of semen for human DI purposes was first established in France where medical practitioners were concerned to offer a better quality medical service than that offered in the “quasi-clandestine conditions of existing DI practices”.

early 1980s. Clinics in New Zealand follow international guidelines that allow the use of frozen semen only after a quarantine period of six months. Because it may take this length of time for an HIV infection to be detected, the quarantine period allows for a second test to be carried out on the donor after this period of time. This practice significantly minimises the risk that the donor had been exposed to the virus that generally leads to the development of AIDS.<sup>7</sup> It also had the effect of extending the time involved in recruiting sperm donors because any newly-banked sperm could not be used for at least six months. Dr A said:

Dr A: ...we were quarantining in, initially it was probably about 1984 or 85, or it would probably be 1984 that we started quarantining for three months and [at the clinic he worked in previously] we were quarantining as well. So that's been around before the law [Status of Children Amendment Act, 1987] came in. So when you set up something now you have to think at least six months ahead. It takes longer than that to get the donors recruited. Now, at that time, all the donor recruiting was done by me. I did all the interviews and things like that. We had [a scientist] who was actually doing the sperm freezing before we had a nurse who was to do most of the inseminations, although initially I did all the inseminations. But by the end of the year '87, things were up and running and going reasonably well. I was interviewing maybe 2-3 new couples a week at that point and we had a queue for a reasonable length of time.

### **Donor Recruitment**

The availability of frozen donor sperm is contingent on maintaining a supply of donors. To ensure an on-going supply, in some countries, such as the United States, semen donors are paid for their contributions to sperm banks (Macklin, 1996:109-110). A system in place in the UK for some time that permits payment to sperm and egg donors of up to 15 pounds plus “reasonable” expenses was recently reviewed and upheld (HFEA, 2000:28). This decision, however, ran contrary to strong arguments posited *against* payments to donors that appeared in the prior discussion document (HFEA, 1998). In France and Germany, donors are not paid (Blank, 1998:140). In the New Zealand context, too, semen donors generally are not paid: the provision of donor semen is largely constructed as an ‘altruistic gift’ given anonymously to unknown recipients. This general understanding of sperm donation as an altruistic act follows the development of policies in other countries, such as France, which endeavoured to transform this procreative arrangement into a morally and socially acceptable act (Novaes, 1989:643). In this context, semen donation became conceptualised as an altruistic “gift from one couple to another”<sup>8</sup> (Novaes, 1989:643)

<sup>7</sup> Copies of information given to clients by fertility clinics appear in Appendix C.

<sup>8</sup> The assumption here is that donors will be part of a married couple who have children themselves and are therefore capable of empathising with the plight of infertile couples who also want children.

in contrast to fostering the image of sperm donors as thoughtless men who “do it for the bucks” (Daniels and Lewis, 1996:9). While it has been argued that the lack of a financial incentive merely discourages a particular ‘type’ of donor (Daniels and Lewis, 1996:4), offering some financial compensation has nonetheless been regarded as necessary by many clinics to ensure an adequate supply of semen (Daniels and Hall, 1997). Concerns have been expressed about the possible cessation of a semen supply as a result of a suggested change in Britain and Canada from a payment based approach to one of non-payment (Daniels and Hall, 1997). Daniels and Hall (1997), who advocate a non-payment based approach, cite evidence, such as the situation in France and New Zealand, where semen donors are not paid, to suggest that non-payment does not necessarily lead to the cessation of supply.

According to health professionals working in DI programmes in two South Island clinics, the recruitment of ‘altruistic’ donors is a perennial problem. In the two fertility clinics included in this study, a female employee is responsible for carrying out the donor recruitment, interviewing prospective donors and any laboratory work associated with making frozen semen available to recipients seeking to conceive by DI. In relation to the difficulties of recruiting enough donors to give recipients some semblance of ‘choice’ of donor, a fertility clinic worker said:

Lab Technician B: Historically, it's been very difficult. When I first started here, there had been periods where they almost had to close the clinic because we didn't have enough donors. I was fortunate in that, not long after I started at the hospital, we did a recruitment campaign and we actually got a huge response. We did a press release and we did local TV, and we did articles in the paper, and we got quite a lot of interest from that. And we ran an ad in the paper. So, from that period, we actually ended up with about 20 donors, and you lose at least 50 percent of them by the time... some don't come in, some come and don't want to continue, a lot of them aren't suitable for whatever reason. So we've still got a hangover from that period, but it isn't easy to recruit donors. I would probably get five [in a year] if I'm lucky.

Lab Technician B highlighted the ways in which advertising and other media exposure can be enrolled to do the ‘work’ of bringing in men who, potentially, can ensure that the DI programme remains operational. Reference to the high ‘dropout’ rate among those who initially expressed an interest in becoming a donor raises the issue of the stringent screening processes which eliminate many potential donors and, therefore, add to the difficulties of maintaining an adequate ‘supply’ of donor semen in DI programmes (Golombok and Cook, 1994). The question also arises as to

whether the screening process might deter potential donors who do not wish to expose themselves to questions about their sexual practices, or to finding out that there was something ‘wrong’ with their semen.

Another obstacle to donor recruitment for these New Zealand DI programmes is that becoming a semen donor requires a high degree of commitment, often with no financial compensation, even for ‘expenses’.<sup>9</sup> The person in charge of recruiting and screening donors at one South Island fertility clinic said of the demands made of donors:

Lab Technician A: They know when they get the pamphlet<sup>10</sup> we send out that they have to have the consent of their partner. They must be prepared to be identified by the children at a later age. They know that. They know there's a lot of openness. They'll get a lot of personal questions asked, like, you know, going to the sexual health clinic, and we look at their own lives, to make sure they have no health risks. It is a commitment. It's not just a matter of coming and giving one specimen. It's a commitment over usually two or three years for the donor. It is quite a commitment for the donor and they find it does take up their time. They've got to be available.

Given the level of commitment required for becoming a sperm donor, the question arises as to why men choose to become a donor. According to the health professionals participating in this study, most donors are motivated by ‘altruism’<sup>11</sup> – the desire to help an infertile couple have a much-wanted child. Dr A said:

Dr A: I've always said that the major reason they come along is their wife pushes them on because they're too fertile, and that's just sort of flippant remark, but...there are a number of couples who go along because they've got friends [who have male factor infertility]. A lot of them are blood donors, and they're sort of that type of altruistic type of person. Occasionally, the reasons they're doing it, we don't understand and usually, if we feel uncomfortable about that, then we're not going to push on. I mean, you occasionally get men who come along and say, “well I think I've got very good genetics and I want to pass them on to mankind”...[interviewer laughs]...well not quite as blunt as that but...and although that may be beneficial to some couples....I once had a phone call from someone who was at a party and had heard someone shout out that he was going to be a sperm donor. That man's sperm didn't freeze very well (he laughs). Yeah, there are a few that do those sorts of things.

Dr A's remark that women are the likely instigators of men's semen donation is borne out by recent New Zealand research on donors and their families which revealed that

<sup>9</sup> Fertility Associates, the largest provider of fertility services in New Zealand do, however, pay sperm donors for expenses.

<sup>10</sup> See Appendix E for information for prospective sperm donors provided by fertility clinics.

<sup>11</sup> Similarly, a recent New Zealand study showed that men became donors for two main reasons. First, they enjoyed being a parent and wanted to help another couple to have the same experience, and second, they had experienced infertility themselves, or knew someone else who had (Adair, 2000:4).

many men had become donors at their wife's suggestion (Adair, 2000:4). This relates to arguments that suggest that women are more likely than men to care about (or are positioned to care about) the problems of others, including infertility (Wellman 1992:103; Williamson 1995). Also illustrating this point, a sperm donor I interviewed for prior research stated that his partner had "pressured" him into becoming a donor. This contention highlights Wellman's (1992) argument that men are domesticated and managed by women, and that this occurs in 'delicate' areas pertaining to masculinity.

Dr A also raised the spectre of the gatekeeping role of the health professional in the selection of donors, and the power of the doctor to determine who is 'suitable' to participate as a donor in the DI network. This parallels the role of the doctor who determines who is permitted to take part in the act of anonymously giving blood and the endeavour to save life (Titmuss, 1970:70). It also highlights the difficulty of determining whether the 'gift' of donated semen is a 'good' one and that, in determining the circulation of such 'gifts', to some extent the doctor has to presume the honesty and truthfulness of the giver.<sup>12</sup> This point was highlighted by Dr A's comment that his working life "revolves around trust" which supports Lupton's argument that trust is a key component of the medical encounter (1996).

Dr A also raised the question of what constitutes an 'acceptable' motive to become a donor. Clearly, motivations that are not in keeping with the dominant discourse of altruism, and are perceived to be overly 'self-centred', are not considered desirable and might lead to a donor not being accepted as part of the programme. Research has shown, however, that donors are motivated for a variety of reasons, such as the desire to help others, or the money.<sup>13</sup> Moreover, Titmuss (1970) has argued that no donor type can be characterised by complete, disinterested, spontaneous altruism. Nonetheless, Titmuss (1970:89) and Komter (1996:302) argue that gifts that are given in the spirit of true altruism (i.e. giving 'something for nothing' with 'no strings

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<sup>12</sup> This screening 'work' is partially performed by technical processes such as medical tests, including blood tests, semen analyses, and trial freezing of semen samples, which play a crucial part in determining whether a man is potentially a 'good' donor.

<sup>13</sup> Daniels (1998b:82-83,89) argues men's motivations to become donors are largely determined by whether the clinic constructs semen provision as a commercial or a 'gift' transaction. In the American context, Hirshman (1991:371) cites a study by Frank and Vogel (1988) that found that donors were motivated by a mixture of reasons including financial incentives, altruism, a sexual thrill, and wanting to procreate their genes.

attached') come closest to Malinowski's concept of the 'free gift'.<sup>14</sup> In this view, anonymous gifts given to unknown strangers are regarded as morally superior even to those that are given as a form of reciprocal exchange. At the other end of the continuum lies the concept of market exchange, which, in the context of this study, raises the controversial issue of the buying and selling of human gametes.

### **Discourses of 'altruism' and 'buying'/'selling' human gametes**

The issue of whether a market economy should exist in the domain of the exchange of human body parts or fluids, including gametes, is strongly debated (see for example Raymond, 1990; Hirshman, 1991; Daniels and Lewis, 1996; Macklin, 1996; Brown, 1999; Daniels, 2000b). Many of these authors draw on Titmuss's seminal work *The Gift Relationship* (1970) on blood donation. Titmuss argued that the UK system of voluntary, unpaid blood donation was morally, medically and economically superior to the American system where many blood suppliers are paid (McLean and Poulton (1986:431).<sup>15</sup> According to McLean and Poulton (1986:341), Titmuss suggested that paid suppliers of blood were more likely to conceal their personal medical history, lest they be prevented from selling their blood, than those who were unpaid, which could lead to the greater risk of tainting of the blood supply. Titmuss was correct but it took the advent of AIDS, which was in part spread by blood transfusion, to reinforce this point. But, as Macklin (1996:107) points out, this argument against commercialism relates to the *quality* of the blood supply which does not clarify why buying human body products, in itself, is somehow morally wrong.

Arguments against paying for human gametes or embryos appeal to ethical concerns about the commodification of the procreative process (Macklin, 1996:115).<sup>16</sup> Or, as Hirshman suggests, they relate to the belief that a distinction should be made between "*sacred* products (such as blood [and presumably gametes]) and *profane* products (such as automobiles)" (Hirschman, 1991:359). Such arguments, according to

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<sup>14</sup> According to Komter (1996:300), Malinowski ranked kinds of gifts on a dimension of reciprocity: at one extreme was the 'pure gift' for which nothing was expected in return (typically the closer the social ties the more gift giving is 'free'); the other end of the spectrum was typified by a kind of market exchange in which both parties were motivated by maximising their profits.

<sup>15</sup> It should be noted, however, that Titmuss's arguments have been widely disputed, particularly by neoclassical economists, who argue that altruistic and commercial models can exist side by side. For arguments against Titmuss's position, see Hirshman, 1991:359; McLean & Poulton, 1986:434-436.

<sup>16</sup> For a discussion of some of the arguments against paying for human gametes, see Macklin (1996:115-116).

Macklin (1996), appeal to moral sentiments that some forms of exchange among humans should not involve the exchange of money. In Macklin's view, this is a judgment about the kind of society that we value (1996:116). She questions whether such moral sentiments are strong enough to warrant the prohibition of commercial transactions of human gametes and concludes that regulation,<sup>17</sup> rather than prohibition, of commercial transactions in this area is the preferable course of action (1996:119).

In contrast to this view, a number of jurisdictions, including Canada, are currently drawing up legislation to ban the buying and selling of human gametes and embryos (Daniels, 2000b). Similarly, in New Zealand, two bills currently before Parliament seek to ban commercial trading in human gametes. One of the bills, which is modelled on British, Canadian and Australian legislation, seeks to ban the sale of body parts, blood, embryos, gametes, foetal tissue, fetuses and babies (New Zealand, 1996:ii). The other seeks to prohibit "trading in human gametes and embryos" (New Zealand, 1998:iii).

Despite arguments against the intrusion of market dynamics in the domain of human life and procreation, gamete donors are still paid in the United States. Recent media publicity about the sale of human oocytes for fees of \$5,000 (or more) highlights the extremes to which commercialism in this area can be taken (see, for example, Mead, 1999). At the same time, it highlights the social context in which the gamete 'donation' occurs. A co-author of recent European guidelines for gamete donation is cited as stating that the commercialisation of gamete donation in the United States stems from the inequalities of the health care system and the premium which Americans are prepared to pay for certain genetic traits (Brown, 1999:29). The latter argument suggests that what people are paying for is the gametes themselves, and the potential genetic endowment embedded in them. Others have argued, however, that within the commercial model operating in the United States, it is deemed more socially, ethically and legally acceptable that donors are paid, not for their actual gametes, but for the "inconvenience, time, discomfort and for the risk undertaken" (Mead, 1999:60). This, according to Mead (1999), is why egg donors, in the United

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<sup>17</sup> This argument relates closely to arguments about prostitution, i.e. paying for sex, as distinct from other 'bodily' services such as therapeutic massage or hairdressing.

States at least (though not in the UK, where, as previously indicated, payment of up to 15 pounds plus expenses is permitted), are paid so much more than sperm donors.

In the case of egg donation, Macklin (1996:109) argues that it is “hard to find a basis for claiming that payment for the risks, discomfort, and inconvenience a donor undergoes is ethically sound but payment for the product extracted as a result of the process is ethically wrong”. In the case of sperm donation, Macklin (1996:110) contends that the presumption seems to be that they are paid for the “product” but concerns about commodification have not emerged. Some writers, however, have expressed concerns that the construction of semen provision as a commercial transaction, as well as the secrecy and anonymity which pervades the practice, have served to deny the social and moral significance of the donor’s actions (Novaes, 1989; Daniels and Lewis, 1996:17; Daniels, 1998b:97-98). Daniels and Lewis (1996:14) contend that financial incentives for sperm donation have been used by health professionals as a means of negating the gift dynamics involved in the transaction that might necessitate an obligation to give something in return. At the same time, financial motivations may be regarded as more straightforward and less ‘suspect’ than, say, ‘altruistic’ motivations to become a sperm donor (Daniels and Lewis, 1996:12).<sup>18</sup>

Dr A raised the issue of whether altruistic or financial motivations to provide semen were more desirable:

Dr A: I mean, I don't know whether it's more pure to do it for altruistic reasons, or for financial reasons, if you think about it. I mean we're brought up with the dogma that it's wrong to pay for gametes and there's a law that's in the process of parliament where we're supposed to not pay for gametes. But I'm not absolutely sure whatever reason is the right reason. [Sperm is] worth more than its weight in gold. [Getting paid] might be a more definable pure reason to do it.... I think probably for eggs it may be better and more ethical to actually just pay for them.

These views relate to arguments that challenge the rigidity of the gift/commodity dichotomy. With reference to these arguments in connection with prostitution, Prasad contends that:

...while gift exchange can be made either sincerely or cynically, commodity exchange can only be made sincerely. That is, gifts can be given either sentimentally and generously, or

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<sup>18</sup> Daniels and Lewis (1996:13-14) assert that health professionals have traditionally sought donors who were not interested in any followup or knowledge of the outcomes of their ‘donation’ to avoid unwanted intrusion by the donor into the recipient’s nuclear family. Constructing semen provision as a commercial transaction between anonymous persons was therefore regarded as a way of completing the transaction.



with the rhetoric of sentiment and generosity invoked ritually to cloak other dispositions. Commodity exchange, in contrast, does not require sentiment on the part of the participants and does not draw forth the ritualized pretense of sentiment. The commodity form offers freedom from the necessity of *appearing* selfless, generous, grateful, or otherwise sentimental and can therefore be construed as free from hypocrisy, while hypocrisy can be ascribed to the gift form (1999:185, original emphasis).

Contrary to dominant discourses that decry the commercial model in transactions involving human gametes, Dr A appeared comfortable with the notion of placing some form of monetary value on human gametes. In the case of egg donation, in particular, he maintained that the risks, inconvenience and discomfort involved warranted some form of financial compensation to the donor. This position relates to arguments about the unfairness of *not* paying donors, particularly when they potentially risk their health, as in the case of egg donation (Macklin, 1996:109). This argument, however, contradicts dominant ethical/legal discourses in New Zealand about the need to avoid the commodification of humans and the sale of any form of human body part. As a result, at the clinic where Dr A is the director, neither semen nor egg donors are paid. Rather than targeting medical students, a traditional source of semen donors (Daniels and Lewis, 1996:13), Dr A claimed that he preferred to target more mature donors. These donors are more likely to fit the profile of an 'altruistic' donor who is not primarily motivated by receiving payment.<sup>19</sup> He said:

Dr A: I suppose the type of donor has changed a little bit. I've not used medical students or anything like that, partly because I don't think they're old enough to make decisions related to those sort of things. Well, they don't know what life's got in store for them really. So I've always viewed a maturer group of donors.

Dr A's comments illustrate the contention that the 'types' of donor recruited by clinics and the meanings attached to the donation will be largely determined by the way semen donation is constructed (i.e. as a commercial transaction or an altruistic act) within the culture of the clinic (Novaes, 1989:643).

When asked if sperm donors were paid in their donor programme, the scientist working in the same clinic said:

Scientist: They never have with our programme. It's been a donation. We've offered perhaps one or two people in the whole 10 years expenses, which is meant to be travelling expenses, but most people don't ask. I think the only ones who asked never got accepted as donors anyway because they weren't suitable for other reasons, so I don't think we've ever actually paid anyone for a donation.

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<sup>19</sup> A recent newspaper advertisement for sperm donors placed by one of the clinics reflects this position. It reads: "Sperm Donors. Healthy responsible men needed, 25-45 years" (Press, 18 October 2000:3).

In contrast to this clinic's approach, the other South Island DI programme did offer a financial incentive to sperm donors: a 'flat' fee of \$150 was offered to donors for a minimum of ten 'donations' - \$75 up front and \$75 when they completed the transaction. But, in keeping with the dominant discourse of the 'altruistic' model, while the amount offered was not insubstantial, it was not enough to provide a major incentive to potential donors. Lab Technician B, who recruited and screened donors for this DI programme, said:

Lab Technician B: Well, we do pay a small amount. We've sort of gone through periods of not paying, but we have for the last few years paid a very small amount. But it's not something I tell anybody. I do tell them that they get paid if they ask. I say, "Yes you do, but if you're doing this for the money, you're wasting your time." And I won't tell them until they come in how much they get paid, and I also don't pay them in one lump sum. I pay them...I split it...they get paid \$150...it's just a flat \$150 and they get \$75 when they've finished donating all the samples, because I ask them for a minimum number of samples, ten....ten doesn't seem to scare them so much...but more than that...so it's a minimum of ten samples they have in the bank. And I just discuss it with them, and you form a rapport with them and usually I'll say, because I'm aiming for a certain number of straws.... An average number is probably 75 to 80 straws.

KH: So, you think being paid motivates people to donate?

Lab Technician B: No, I don't, no. I think it's probably something we may review, because I think what happens is...I mean I've had the odd one who it has been and they often say that it is motivating, but it's not the only one...you can tell the ones that it is the only one. I mean it's nice, if they're a student in particular and they're struggling a bit, anything is a help, but you can usually tell whether that is their main incentive.

Daniels (1998b:89) argues that a financial motivation is more likely to be associated with student donors which suggests that this DI programme, located near a medical school, is more likely to target students as potential donors. Lab Technician B indicated that they recruited donors from "all walks of life" but most were university educated.

### **Screening Donors**

Before being accepted by the DI programme, potential donors submit to rigorous health checks, including sexual health, and producing specimens of semen and blood. Lab Technician B referred to the donor screening process:

Lab Technician B: What happens is a blood screen for HIV, Hepatitis B and Hepatitis C...and the semen is quarantined for six months from the time of the last ejaculate, and after that length of time we bring them in again for HIV and we also screen again to make sure they haven't thrown anything up during that time. They would be turned down for the programme if they had any STD. We don't send them to the STD clinic here. What we do is, we have a health questionnaire, but they're basically things like diabetes, high blood pressure, any coronary

disease, anything like that, and have they had any symptoms which may indicate that they had an STD. I also ask them if they've ever had an STD or hepatitis. They give a brief family history, and they're also asked about any hereditary disorders, and it's just a list that we get them to go through. And then there's a donor declaration that they have to sign, and they have to let us know if they have any symptoms of an STD or if they participate in any activity that may put them at risk, and they're also asked to report anything during the period of the programme.

As well as screening for any possible contagious disease, clinical staff said they had to feel that the donor was being honest and truthful about his family medical history. With regard to making this judgement about prospective donors, the person in charge of recruiting and screening donors at the other clinic said:

Lab Technician A: We have to feel comfortable with the donor, that the donor is being open with us. If I didn't like a person, that wouldn't be a reason for excluding a donor. We'd have to be comfortable that everything was okay, that they were being honest and completely open, and telling you everything there was to know about them. They have to pass all the medical family history things, and then the sexual health clinic screen, which is pretty thorough, and then bring a sample in for a trial freeze. So those are really the three things. And from now on they're going to have to go and see a male counsellor outside of our centre as well, just to talk through the implications before they actually come in to you, so they've really thought through the issue of having genetic offspring out there, although they're not their children.

Lab Technician A highlighted the importance of trust in the donor screening process and the need to make subjective judgements about the donor, which constitute a different form of appraisal than the medical tests donors are required to 'pass' before being accepted into the DI programme. Similarly, Lupton's study of lay persons' experience with medical practitioners indicated that people wanted to "feel comfortable" with their doctor, which highlights that trust is required on both sides (1996:160).

According to Dr A, only about a third of potential donors get to the stage of submitting semen for a trial freeze. Only after reaching this stage are potential donors required to attend a counselling session to ensure that they have considered the implications of anonymously donating semen that could lead to the birth of a child to whom they are biologically related in someone else's family. This counselling session constitutes yet another part of the screening process that might eliminate potential donors from the programme. The counsellor does not turn down donors, *per se*, but reports to the clinic director any concerns he/she has about their suitability. With respect to the RTAC<sup>20</sup> requirement that donors are counselled, Dr A said:

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<sup>20</sup> The Reproductive Technology Accreditation Committee of Australia (RTAC) became the accreditation body for all fertility clinics in New Zealand in 1990 at the instigation of some service

Dr A: To a degree, I've tried to keep the hurdles down to the donors to encourage them, and I feel it may be another hurdle that's put in their way. I can understand why people think it needs to be done, but I also wonder whether we're going to counsel everyone before they make a decision. And reproductive technologies are posed with so many things. I mean, it's much easier to get a heart transplant (he laughs).

Dr A's comment hints at the possible tensions that exist for health professionals. Whereas clinics are primarily in the 'business' of 'making babies', they nonetheless have to adhere to a raft of ethical and medical (if not legal) requirements to address the possible 'risks' to all parties to procreative processes involving the use of third party gametes.<sup>21</sup> This also speaks to the collision between what Law (1994:77) refers to as two different modes of ordering: administration and enterprise.<sup>22</sup> According to Law (1994:75-76), stories of enterprise tell stories about agency and celebrate opportunism, pragmatism and performance. In contrast, administration as a mode of ordering entails stories about generating the perfectly well-regulated organisation, about hierarchical structures and about management as the art of planning, implementing, maintaining and policing that structure (Law, 1994:77). The requirement to 'police' the screening of donors on the basis of their health status, and additionally, to ensure that they have considered the 'social' implications of their contribution to the birth of a new human being, illustrates the heightened concerns about risk and uncertainty in contemporary society (Petersen, 1997). According to Castel, contemporary society, labelled "high modernity", is characterised by the emergence of new preventive strategies in social administration which "dissolve the notion of the subject or a concrete individual, and put in its place a combinatorial of factors, the factors or risk" (cited in Petersen, 1997:192). One possible 'risk' relates to the issue of donors providing less than perfect gametes. Another possible risk

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providers who were concerned about the lack of a government-instituted system of accountability in the field of assisted human reproduction in New Zealand (Daniels and Hargreaves, 1997:3)

<sup>21</sup> At a meeting on 5 June 2001 at one of the fertility clinics included in this study, a doctor referred to new criteria for screening donors which included lowering the maximum age of donors from 45 to 40 years old. The new criterion has been instituted because medical research has shown that the incidence of schizophrenia is greater in people whose fathers were over 40 years old when they were conceived. This relates to recent research carried out in Israel which found that men aged 45-49 were twice as likely to have offspring with schizophrenia as were men under 25 years old (see Malaspina, Harlap et al, 2001). This new criterion represents a further barrier to recruiting donors. Previously, RTAC guidelines had allowed semen donors to be up to 55 years old. See Appendix D for RTAC guidelines relating to the use of donor gametes.

<sup>22</sup> Law (1994) argues that there is no social 'order' as such. Rather, there are modes of 'ordering' which are never complete and jostle together to generate the social. He argues that these modes of ordering are strategies for patterning the networks of the social (1994:20). Law outlines four modes of ordering: enterprise, administration, vision and vocation (1994:75-82)

relates to the potential of being identified by their donor offspring in the future, and whether, in fact, they will be available to be contacted.<sup>23</sup>

In the current New Zealand context, the potential of being identified in the future by individuals conceived with the use of their donations is one of the major issues that donors have to consider before becoming a donor. The director of another South Island clinic expressed concerns about this:

Dr C: ...you may know that all the clinics in the country have a policy of accepting donors who are prepared to be identified. We never had that formal policy, except that we advise our donors and after counselling as well, and it's interesting that I don't think there'd be any donor who is not prepared to be identified. We have donors come in who say they're not, but after counselling they have changed their minds. So, whether they've looked at it and realised....The issue about the identifiability is a difficult one though, and one I'm concerned about. I mean, for example, because it's not in the legislation, what do the clinics do to ensure that they remain in contact? The real problem will come 10, 20 years away, knowing my own research, [donors] may shift, and although they say they will be happy to meet the child, they don't have to.

Dr C identified the 'risk' for people conceived by DI who, according to dominant discourses in the field of AHR in New Zealand, have the 'right' to be able to identify their genetic father in the future.<sup>24</sup> Without legislation in place to ensure that this 'right' can be exercised, it cannot be guaranteed.

Other forms of 'risk' potentially inhere in the issue of donor identifiability. Questions arise about the effect on the donor himself, or his family network, of having DI offspring who seek to meet him. In connection with the possible 'risks' to donors and DI offspring, Dr A said:

Dr A: ...the philosophy of the clinic is that it's the child's right to know. All of our donors that we have are in agreement that they may be contacted in the future. We tell everybody that. We can't guarantee that because there's no obligation for the donor not to change their mind....You know, you can envisage a situation, say, that if we allow four conceptions and some couples may have another conception with that donor. If the first family that turns up at the donor's door turns out to be, to coin a phrase, real rat-bags, then he may not be willing to make himself available for other people. And unless there's an obligation within the law, then there's not much we can do about that.

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<sup>23</sup> In connection with the issue of identifiable donors, Daniels (1999b:7) cites the report of a medical professional following a workshop on issues related to AHR. The report stated: "Many centres are looking for donors who are prepared to be identifiable to the children in the future and, contrary to previous belief, most donors are prepared to do this. It was suggested that only men prepared to be identifiable should now be considered as donors".

<sup>24</sup> One of the guiding principles of the Ministerial Committee on Assisted Reproductive Technologies was the right to know one's genetic origins (MCART, 1994:33). The Committee argued that this principle was important within the New Zealand context because of the significance of whakapapa (knowledge of one's ancestry) for Maori, and that many pakeha recognise knowledge of one's biological origins as important for the discovery of identity.

Because of the possible implications for donors' partners and children, donors are also asked by the DI programme to gain the consent of their partner, if they have one, before they will be accepted onto the programme.<sup>25</sup> One DI programme did not require the written consent of partners; instead, donors are asked if they have their partner's consent, and partners are invited to attend an interview with the potential donor to help the couple make an "informed decision".<sup>26</sup> The other clinic, however, required written consent from partners of potential sperm donors. According to the director of this South Island clinic, a donor's partner has the 'right' to be involved in the consent to supply semen for the DI programme and also in the determination of who has access to the semen.<sup>27</sup>

Although health professionals suggested that it was the donor's 'right' to determine who had access to his sperm, donors (and their partners) are *required* by clinics to make a decision about who can have access to 'their' semen. Thus, donors (and their partners) enter into a legally-binding agreement with the clinic about the 'types' of recipient that may use their sperm (MCART, 1994:54). This form of 'targeting' is not considered by the Human Rights Commission to be in breach of the Human Rights Act 1993. The information pamphlet sent out to the donors by one of the clinics stipulates that, although the Human Rights Act 1993 requires the clinic to offer DI without discrimination, because the donor is "making a gift, he is free to choose where his gift goes". It should be noted, however, that while the donation of semen is constructed as an 'altruistic gift', when donors are asked to 'target' particular recipients of their 'gifts' the notion that the gift is given in the spirit of Malinowski's 'free' or 'pure' gift is undermined. At the same time, it does distinguish it from a commercial transaction where no such preference is stated. When asked about the categories of recipients stipulated by their clinic, Lab Technician A said:

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<sup>25</sup> A recent study of New Zealand donors revealed that half the donors who were married/partnered were no longer with their original partner (Adair, 2000:4-5). Some of the current female partners had concerns that possible demands on their partner by DI offspring might result in time taken away from their own family.

<sup>26</sup> See Appendix E for donor information.

<sup>27</sup> RTAC guidelines on the storage and use of donated gametes (see Attachment E in Appendix D) stipulate that if a donor is married or has a long-term partner, "centres should *encourage* donors to ask their partner to consent in writing to the use of the gametes for treatment" (emphasis added). The social worker who currently counsels anonymous sperm donors at this clinic said, at a meeting I attended at the clinic on 5 June 2001, that although he attempted to see donors' partners to discuss the implications of their partner's semen donation, frequently this was logistically difficult and did not happen.

Lab Technician A: There used to be just [heterosexual] couples coming through, but now, because of the Human Rights Act, we're also treating single women, lesbian couples. The categories that we put in front of the donors are married couples, de facto couples, single women, lesbian couples, people with a history of a psychiatric problem and people with a criminal background, and couples of a different ethnic origin. So they're the different groups we might have coming through, and some of the donors have quite strong feelings about any one or other of those groups. So, they're asked that at their initial interview. They tick what they think there and then. We give them a copy of that to take back and sort of stress that they can come back and change that, and then some will come back and change. Usually they do it straight off.

Most are comfortable with married couples and de facto couples...would be the most general. Most specify for a criminal record that it would depend on what it is and how long ago. Probably most...some aren't worried about ethnic origins, some are. And then, fewer are happy about single women or lesbian couples, so that's harder to get donors for.

Donors at this clinic are asked to rate how “comfortable” they feel (on a five-point scale from “very uncomfortable” to “completely comfortable”) about their semen being used by the categories of recipient stipulated on the clinic’s questionnaire on semen use. This is given to donors and their partners to complete (see Appendix E). In addition, donors are asked to stipulate whether they wish to withdraw consent to use their semen for any particular categories of recipient. These procedures, and particularly the rating scale, appear to offer a great deal of scope for the exercise of discrimination or social control by the clinic, implied by the categories they offer. It remains unclear as to how the clinic uses information from the rating scale to offer or withdraw semen from certain donors to particular recipients. For example, if a donor stated that he was “indifferent” about whether single women or lesbian couples had access to his sperm, would they in fact have access to it? As a result of this process, the DI programme had only one or two donors who were prepared to donate semen to single women or lesbian couples. Dr A said:

Dr A: Certainly, that’s probably where the greatest pressure on the system is at the moment, primarily because we don’t have so much semen available for those people [single and lesbian women], because the donors are asked what group of people they would like to have their semen used for, or are there any specific reasons they wouldn’t want [to donate to certain people]. That’s the donor and usually the donor’s partner because they have a right to be involved in that. Interesting that [some women claim that] semen comes under the [Matrimonial Property Act].<sup>28</sup>

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<sup>28</sup> Dr. A’s reference to the Matrimonial Property Act 1976 was made in jest. The Act does not include reference to human gametes, so there is no basis in law for this clinic’s decision to require written consent from partners of sperm donors. Dr A’s comments referred to his perception that many women felt they had a ‘claim’ to their partner’s sperm and were uncomfortable with the notion of them procreating outside their own nuclear family and with another woman. This relates to discussion in Chapter Four about using a known donor.

In contrast to this situation regarding the accessibility of donor semen to single and lesbian women, the person in charge of recruiting donors for the other South Island DI programme said:

Lab Technician B: I couldn't tell you the number. It's interesting though...I mean, it surprises me actually. I'm really surprised. I mean there are definitely, probably, maybe half of them. The ones that I've talked to recently...none of them consider it a problem, and they don't have any problems at all. I'm quite amazed actually...especially the ones who immediately say, "I don't have a problem with it. It's not a problem, as long as they have a good home environment."

This DI programme appeared to have recruited a more 'liberal' group of donors than the other clinic. This might partly be a reflection of differing clinical practices, including that this DI programme was more likely to recruit donors from the university than the former clinic.<sup>29</sup>

As well as asking donors (and, where appropriate, their partners) to make a decision regarding who may receive their sperm donations, DI programme staff also informed donors that they should think about telling their 'own' biological children of the existence of any DI offspring, who were genetically their children's half-siblings.

Lab Technician B: I just put that to [donors] in the interview and they have to think about that...that they should think about telling their children or any future children. I sort of prime them, so that I make sure that they're thinking about it before they go to [the counsellor] so that when they go to her, they've actually had time to consider it and discuss it with her.

In contrast, the lab technician at the other clinic appeared to be more proactive in recommending that donors tell their children of any DI offspring. The scientist in the same DI programme commented that donors face the issue of how to tell their children about their DI offspring. She said:

Scientist: What we also need is a book for donors and how to tell *their* children, because they face the same issue. They need to tell their children that there are half-brothers and half-sisters in the community. And it's very much the same sort of thing. It's perhaps just a little bit less immediately personal but I'm sure it's still quite difficult for the donor and his partner. So someone needs to write one for us.

KH: That's a good idea, because they might not even have all their own children at the time they donate.

Scientist: No, that's right. They may not. Some of them are single and will then subsequently get married and have children much later. Some have got them already, but they're quite small and too young to be told.

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<sup>29</sup> To determine specific reasons as to why this might be the case would require further research including interviews with donors.



At a recent meeting at the clinic, the counsellor of anonymous donors claimed that some donors had said that they did not think their children needed to know about their donations. This perception is supported by recent research on donors in New Zealand which revealed that most had not told their children primarily because they were regarded as “too young”, although most were adolescent (Adair, 2000:5). According to Adair, the 23% of donors who had told their children of their involvement in a DI programme received no negative reactions from their children, most of whom were “only mildly interested” (2000:5). Adair suggests that, given the concerns of many donors’ wives about romantic attachments between half-siblings, informing children about the existence of any half-siblings in the community seems advisable.

### **The Collection, Storage and Sharing of Information in Donor Insemination**

At the two clinics included in this study, donors are asked to provide non-identifying information about themselves which is then provided as a ‘profile’ for recipients to view when choosing a donor, and is sent to them in the event that they had a baby by a particular donor.<sup>30</sup> Lab Technician A, who recruits donors at one of the clinics, said about the non-identifying information that donors provide:

Lab Technician A: It’s basic physical features, like their height, hair colour, all those sorts of things. The donor’s own health history, if he’s had any illnesses, and his eyesight, whether he’s left or right handed, smoking and drinking, his education level, his employment, what sort of job he’s in, and then a basic family history of his parents and his grandparents. So there’s a bit of family [information]...just roughly their physical features and what they did, and then some personal comments which we like to get from them. Why do you want to be a donor? Is there anything else you’d like to say about yourself...what sort of personality, and any comments from your partner? I hear from the nurses that recipients are quite interested in those personal comments. They just like to get a bit of a feel for the person.

Non-identifying information provided by donors is typed up into a profile which is then placed in the appropriate folder (labelled according to recipient ‘type’) from which recipients can choose a donor. Each donor profile is identified by a donor code which is printed on the top of the page. To make sure the donor remains anonymous, the clinic reserves the right to edit non-identifying information that might potentially identify the donor. Nurse B said:

Nurse B: The girls, when they do the profiles, are very careful about what they allow the donors to write. The profiles mention your occupations, and the things you’re interested in, your sporting, musical, artistic...you know, all those sorts of things. They’re sort of fairly broad profiles, and I remember interviewing, because we nurses used to interview the donors, and I

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<sup>30</sup> Donor Non-Identifying Information forms are located in Appendix E.

remember interviewing one donor and he was a helicopter pilot. When he wrote out his profile he wrote, "helicopter pilot", and [Lab Technician A] said, "Well you can't actually put that in because there's not many helicopter pilots. And if anybody came in who knew something about helicopter pilots, it wouldn't take, I mean you wouldn't have to be a rocket scientist to work out, just looking at the physical features to work out who you were." So when they actually do the profiles, they do guide, or they ring and make suggestions, that perhaps we would change this or that, if it was going to be something that was rather specific.

At this clinic, while donors write their own profiles, they are scrutinised and modified to make sure that donor anonymity is preserved. In contrast, at the other South Island DI programme, donors handwrite their profiles which are then photocopied for recipients' viewing. Considering that handwriting might be an easy identifying marker, this seemed a 'risky' practice in relation to preserving donor anonymity. This is particularly the case given that the clinic's nurse said that she selected the profiles of three donors that she deemed suitable for the couple and posted them out for them to make a choice. Lab Technician B said:

Lab Technician B: [At] our clinic we just photocopy the non-identifying information [form filled out by donor] and [recipients] are given that. They're actually given a few of those to choose their donor from. But, it's things like education, what they like doing, don't like doing. They also put their physical characteristics and age range. The last question is to do with parents and grandparents. We've just got a general question, "How is your health? Do you suffer from...? Do you drink? Do you smoke? What is your motivation? Anything else you want to say?"

While recipients receive a textual representation of the donor, clinical practices are designed to ensure that the donor remains anonymous and therefore a generic, rather than a specific individual. The attention given by health professionals to preserving donor anonymity raises the question as to who benefits from the anonymity which is a central organising principle of DI programmes. Haimes (1990:158) suggests that distancing mechanisms such as donor anonymity are usually assumed to be in the best interests of the donor, the child and the recipient couple. After examining reports on the use of assisted human reproduction in Britain, written in the mid-1980s (including the Warnock Report, 1985), Haimes (1990) argues that anonymity serves as a device "to protect the anomalous family and to promote the ideology of 'family life'" (Haimes, 1990). Donors are rendered "invisible" so that "families-by-donation" can conform to the ideological and structural requirements of "normal families" (Haimes, 1990:167). Daniels (1998b:83) has argued that payment to donors is a distancing mechanism to bring finality to the transaction and remove the notion that donors are owed anything further, such as information about outcomes, counselling or social recognition.

Haimes has also argued that clinicians themselves have benefited from donor anonymity, particularly in the past, because it has protected them from the scrutiny of others who might have doubts about the practice of DI (1993c). This might be the case particularly if clinicians sometimes are donors. Haimes suggests that important legal and social developments in relation to gamete donation in the 1980s and 1990s have probably led to clinicians being less concerned about promoting secrecy and anonymity.<sup>31</sup> But, Haimes (1993c:1519-1520) argues, two important factors support the continuation of donor anonymity as a central organising principle in DI: first, the fact that recipients are still strongly in favour of donor anonymity; and second, that gamete donation takes place “in a society which still feels a great deal of uncertainty about the significance (physiological as well as symbolic) of genetic relationships in the development of the individual and in the development of families” (Haimes, 1993a:1520).

As another distancing mechanism for preserving anonymity, in each of the two DI programmes, different staff members have contact with donors and recipients. The scientist in one of the DI programmes said:

Scientist: We set up some time ago, a sort of division between the donors and the recipients. And we felt that there were certain advantages to having different people deal with the donors and deal with the recipients. Then each one becomes somewhat an advocate for the group that they deal with and tends to look out for their interests and we feel that that's worked fairly well. Before that, there was perhaps potential for putting undue pressure on donors from someone who was very involved with a recipient and wanted something for them.... For the donor it always is a donation. It's something he's giving, something he's doing, and there shouldn't ever be pressure brought to bear on him, and his interests always have to be considered, and his wife and family too. They're individuals in their own right, and with their own rights.

In this DI programme, donors are recruited and screened by andrology laboratory staff and recipients interface with DI programme nurses. In the past, the scientist was involved with donor recruitment and undertook all the scientific lab work, such as sperm freezing, but now she had very little contact with donors, except to write the newsletter which donors receive from the clinic.<sup>32</sup> With regard to the newsletter,<sup>33</sup>

Lab Technician A said:

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<sup>31</sup> These developments include growing public interest and knowledge about infertility, the growth of ovum donation which has provided an alternative framework for understanding the motivation of gamete donors and the passing of legislation in some countries to provide access to identifying information about donors when the children are adults (see Haimes, 1993a:1519).

<sup>32</sup> According to the scientist, this method of on-going contact between the fertility clinic and the donors has enabled them to stay in contact with 90 percent of their donors. In contrast, because they have no on-going contact with recipients, the scientist claimed that this project, and her involvement in trying to

Lab Technician A: They have a newsletter about twice a year, and that just tells them what's going on in the clinic and if there's any changes in the centre. And then within that newsletter, each donor will get the information of how many inseminations there has been in total, and whether there have been any pregnancies, and also whether there have been any live births, because obviously not all pregnancies result in a live birth. So they are informed whether they have any children and what sex they are. [Donors] seem to almost universally be keen to get that information. If they don't get the newsletter they ask when another newsletter is coming out (she laughs)! So they are keen to know.

According to Daniels (1998b), contrary to general beliefs, several studies on donors carried out in New Zealand and other countries has shown that many donors are interested in knowing the outcome of their donations. This included knowing about numbers of pregnancies and births and, in some cases, wanting to receive photographs of the offspring (Daniels, 1998b:90). Other recent New Zealand research on donors also found that many donors were interested in receiving information from the clinic about any DI offspring (Adair, 2000). Lab Technician B, who recruits donors at one of the fertility clinics, said that many donors are very interested in whether or not children have been born as a result of their donations. She said:

Lab Technician B: Some of them, the odd one says, 'I'm not interested.' Most of them are very interested to know, certainly interested to know that there are children. And we tell them that there are children and they are interested in that. And some of them... I have had the odd one say he couldn't go on with the programme because they couldn't cope with the fact that a child of theirs was in a home that they didn't know what it would be like...they had control over...and they really had gone to a point, and then no, they couldn't...they never got to the point of donating. They'd gone through talking to people, and at the end of the day they really found it very difficult...I've had two or three people like that. And, yes, they are interested in the children.

Furthermore, Lab Technician B said about the limited information passed on verbally to donors she recruited:

Lab Technician B: They're just told. They are told they have x number of children and they're told the sex, and that's all they're told. They're not given any indication of when they were born, where the children are living, *nothing*. That's it. And they know that. And I just tell them that they must understand that although there's a child, they're not able to make any contact with that

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recruit recipient couples had highlighted that the clinic had lost touch with many of their recipient couples.

<sup>33</sup> A copy of a donor newsletter dated December 1995, appears in Appendix E. Amongst other information, the newsletter provides statistics on the numbers of babies conceived by DI through this programme, by sex, born between 1987-1995. In their December 1995 newsletter, clinic staff working with donors wrote that donors who indicated on their non-identifying information form that they were willing to be contacted by any offspring in the future, could ensure that this was possible by leaving details with their family solicitor. The clinic was planning to establish this as a mechanism to ensure that donors could be contacted by DI offspring in the future. Thus, it appeared that the purpose of the newsletter is not so much to provide "news" as a means of control: to maintain contact with the donor.

child. It's a one-way street. And they just accept that. They do. They know that. We've had the odd one who would like to, but, yeah, they accept it.

With no legislation in place governing access to information, according to current clinic practices that aim to preserve anonymity between donors and recipient families, donors have to accept that they cannot make contact with their biological offspring.<sup>34</sup> Any move towards a meeting between the donor and his DI offspring would have to come from the individuals conceived by DI. The question arises, however, whether donors have the right to receive non-identifying information about recipients.<sup>35</sup> When completing the donor questionnaire at one of the clinics, donors are asked if they would be interested in receiving this information. The scientist at this clinic said:

Scientist: [An issue] that's always been vaguely niggling around is would the donors like non-identifying information on their successful couples? That's something we ask them all with their forms, and most of them say they would be very interested in this information but we've never actually provided it. ...They know if [DI offspring] exist, but unless they specifically ask, they don't even know how many to one family. I just print out a total and that says three boys, two girls. So they know the total numbers and they know roughly when they were born because these six-monthly newsletters pin it down to a period of six months.

Like the scientist, a mother of three children conceived by DI also raised the issue of families sharing information with donors. She said:

Stephanie: ...some people are very threatened, again probably I'm considered a liberal, but my attitude is if you believe that the children should have access to the information about the donor then I think there's some reciprocity in there. And I don't feel threatened by that, but I know a lot of people do. And that's another issue that I think needs to be addressed. ...when I donated eggs, that was one of the specifications I set down, that I wanted to know the outcome. I didn't really want to be in their life, but I wanted to know the outcome. And I also wanted...the reason I wanted to meet the recipient was that because I felt that it would be more difficult for them to convince themselves that I didn't exist, if they actually met me...had seen photographs of my family and done all those sorts of things. And so, you could never actually make them tell the child, but you actually were cutting off the ability of them to actually deny...which made them more likely to tell.

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<sup>34</sup> It should be noted, however, that the assisted reproductive technology bills currently before the New Zealand parliament give donors the 'right' to access information kept by fertility clinics, or the Registrar-General on children conceived with the use of their donated sperm. The bills recognise the rights of persons conceived by assisted conception, the rights of genetic parents, and the rights of adoptive parents to information about the parties to such procreative arrangements (New Zealand, 1996; New Zealand, 1998). At the time of writing, it was anticipated that the report of the Government Select Committee on these two Bills would be published in November 2001.

<sup>35</sup> In a previous study, a donor I interviewed indicated to the fertility clinic that he would be "very interested" in receiving non-identifying information about couples who had children conceived with his sperm. He also said that he would feel comfortable with contact from the recipients via a letter when the child was no less than 14 years old, unless the parents felt that it was necessary prior to that time. Nonetheless, he was cautious about actually meeting any offspring saying that he would want to know exactly what they expected to achieve by such a meeting.

Although a recipient of donor sperm, Stephanie was able to position herself as a donor because she had donated eggs to another couple after she had had her three children and ‘completed her family’. As a donor herself, she wanted to know the outcome of her donation, and also to actually meet the recipients, with the specific objective of ensuring that they would be more likely to tell their child how he/she was conceived. This highlighted her strong commitment to the notion that individuals conceived using donor gametes should be told of their origins. Stephanie’s support of the sharing of information between parties to a DI conception subverts the notion that families with children conceived by DI need to conform to the ideological and structural requirements of “normal families” as discussed by Haimes (1990) in relation to recipients’ desire for donor anonymity. Stephanie’s experience also highlights the fundamental difference between sperm and egg donation programmes in the New Zealand context. Whereas DI programmes have an over-riding concern with donor anonymity, egg donation programmes generally do not because ovum donation has been framed as altruistic donation in contrast to the suspected pathology traditionally associated with semen donation (Haimes, 1993:1519).<sup>36</sup>

### **Maintaining donor records**

Many countries that have addressed the regulation of DI practices require record keeping but they differ as to what should be done with the information (Blank 1998). Some countries, such as the UK, have established centralised registers of information on all assisted conceptions and gamete donors (Blank, 1998:147). Most countries, however, seek to preserve donor anonymity and therefore allow access to non-identifying information only. Exceptions to this exist in Sweden, Austria, the State of Victoria in Australia, and Switzerland (1998) and Holland, which have instituted laws that require that identifying information about sperm donors be accessible to donor children when they reach the age of eighteen (Blank, (1998:146). The Australian Medical Procedures Act 1988 provides for the establishment of a central registry to hold certain non-identifying and identifying information but the latter may be accessed only with the written permission of the person enquired about (Blank, 1998:146).

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<sup>36</sup> The differences between the way that sperm and egg donor programmes are constructed and the different social meanings attached to sperm and ova are discussed in Chapter Four and Chapter Ten.

New Zealand fertility clinics are required, by the accrediting body, RTAC, to collect information about donors, but at present there is no legal obligation for clinics to do so (MCART, 1994:86). The DI programmes included in this study maintain records so they can link donors with particular pregnancies and this information is kept by individual clinics. Record-keeping is therefore maintained at the local clinic level which secures medical control over information. Questions have arisen, however, as to whether there should be a centralised register of births as a result of gamete donation (MCART, 1994:86). This would secure management control by the Registrar-General over information at the national level. As previously stated, the two bills, currently before Parliament, relating to the regulation of assisted human reproduction in New Zealand, make provision for the establishment of a central register. Subject to certain limitations, this ultimately would enable both donor offspring and donors to access identifying information about one another (Assisted Human Reproduction Bill, 1998; Human Assisted Reproductive Technology Bill, 1996).

In relation to the prospect of the establishment of a central register of information related to donor conceptions, the director of one of the DI programmes said:

Dr A: I would think there ought to be a register set up for donors so that...a national...when a child is born there should be a name on a register somewhere. I think it should be held in a place that doesn't have access to busybodies and things like that... with very limited access to it. I mean that's really what we're doing in an essence. We get to keep track of those things. But I don't know what's going to be happening to me in 20 years either.

Dr A appeared to have some doubts about losing control over the information at the local level because of the possibility of breaches of confidentiality. His comment about uncertainty of his personal future raises the spectre that records might be lost if kept at the local level. It also suggests that, like other centralised registers such as the National Cervical Screening Register, a register of donors and their DI offspring attempts to construct standardised networks that ensure certainty in a field of uncertainty (Phibbs, 2000). The medical practice of DI, for example, has been perceived as creating uncertainty about fatherhood and the 'risk' to individuals conceived by DI of not being able to trace their genetic father. These factors are attributed to the secrecy and anonymity traditionally surrounding the practice (Price, 1997).

Centralised registers are implemented and used as management tools and as surveillance mechanisms that constitute a regulatory control by state actors of a particular population.<sup>37</sup> According to Austrin and Phibbs (1996:17), in Foucauldian terms these registers can be seen as modern technologies of power through which a constructed medical gaze is able to penetrate and organise a population. They may also be used to smooth over competing claims within a contested medical field (Austrin and Phibbs, 1996:19). For example, the operation of a register containing information that links donors, recipients and DI offspring, might allow access to information about the parties to a DI conception, even if one of the parties wishes to remain anonymous. In contrast to arguments that favour the development of a national register, a scientist working in a DI programme was not in favour of centralised record-keeping. She said:

Scientist: Well, my personal view is I'm not in favour of it, though Dr A seems to be of the notion it probably will happen eventually, but I sort of feel that the number of clinics in New Zealand is so small. There are so few of us, it's so easy to communicate between them, that it could be something that could be kept quite securely at the level of the clinic where the person is treated. In terms of security for people who don't want to know... the couples I think they need to be in control of this information. If they want people to know they need to tell them. They don't want anything to be found out without their actual control over it. So, in terms of that, the fewer people who know, and the less widespread the information is, the better, and any sort of central register, there's obviously going to be people typing it, it's going to be available, and New Zealand's a small country. There's always scope for mistakes and leaks and things.

The scientist raised an important point about who should own personal information. Her views indicated that issues of control over access to information are central to arguments about whether records should be maintained at the local level or centralised in a national register to facilitate the sharing of information to those who are deemed to have the 'right' to access it.

Questions have also arisen about the desirability of sharing information between families with children conceived by the same donor. In 1997, a Donor Family Register was piloted by Fertility Associates in Wellington New Zealand. The idea for the register was conceived by Sylvia Nixon, a nurse working in Fertility Associates' DI programme. At a public launch of the Donor Family Register at an Infertility Awareness Day, hosted by the NZIS, on 16 August, 1998, she said:

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<sup>37</sup> See Austrin and Phibbs (1996) for an analysis of the implementation of two registers in the medical field in New Zealand: the Cervical Screening Register, a centralised register administered by the Department of Health, and the Implants Containing Silicone-gel Register, a decentralised register administered by individual plastic surgeons with the co-operation of the Department of Health.



Sylvia: Back in 1988, a donor family support group, which I hosted, was shocked into stunned silence momentarily by an observation from one mother (who happens to be here) that there was a strong likelihood that some of the children present were half-brothers and sisters. A few awkward glances were exchanged and obvious discomfort felt by some couples. But of course, she countered, only Sylvia is the one with that information. Hello! That light bulb went on again. She was in fact correct. Some of the children present were related through the donor and I was the only one who could readily access that information. That responsibility remained with me.

Sylvia became aware that it might be in DI families' interests to know which other families had children by the same donor, particularly as many parents have concerns that half-siblings might meet, be attracted to one another and form a relationship. So she began to devise a mechanism by which families could share and access information – either non-identifying or identifying – between themselves. She said:

Sylvia: The objective for the register is to provide an accurate accessible means of allowing information to be shared by families conceived by the same donor, and perhaps more importantly, a way that the offspring of these families, as young adults can check the number and gender of their half siblings. All donor families will have basic information stored. That is they are family X to donor Y with a male born in 1988 and a female born in 1991. This is the only information that will be released to other linked families until such time as that family gives permission or otherwise. Looking to the future, having suitably identified themselves, donor offspring as adults will also be given the opportunity of storing and accessing information.

When I raised the topic of the Donor Family Register, the scientist at one of the DI programmes argued that there was no need for a central register of DI families. She said:

Scientist: I think that information is actually available. Yeah. And if they wish to meet other couples and the other couples were willing. As long as you've got two willing couples, you can put them in contact with each other. I know we've talked about it, and I had the feeling that to some extent it had happened. Then the issue arises as to whether the donor's children would want to meet the others. But then that can't be done without the donor himself at least until they reach a slightly more advanced age. But I know quite a long time ago we had the notion that perhaps the connections between the half-siblings is more important than between the children and the donor father even. That to know your half-brothers and half-sisters might be a more longterm relationship and a more significant one. It's like having another whole batch of cousins, and a whole extension to your family. It could be a really good positive thing for a lot of kids.

Two recipient couples included in this study, with children conceived with the use of sperm from the same donor, had had telephone contact with one another. This was initiated by one of the mothers with two daughters conceived by DI, who had contacted the clinic to ask for information about other families who had used sperm from the same donor. This was spurred by her concerns about her daughters later developing relationships with genetic half-siblings. She said:

Caroline: ...when I hear about all the couples that are having donor insemination...it worries me that, gosh, you've got to be careful about who our daughters then decide to get involved with.

KH: You mean in case they meet a male...

Caroline: Who may be related to them. But then again, there are so many children out there who don't know who their fathers are anyway, that... the chances of it happening I suppose are very slim, but it is a little bit of a worry.

Caroline had been in contact with the other family who had children of a similar age to her own. She had told Toni, her eldest daughter, who was 8 years old, about the existence of these genetic half-siblings. She said:

Caroline: I mentioned it to Toni the other day that there was this other family down here who had used the same biological father, so I said, "in theory they're like your half-brothers and sisters" and she... her eyes lit up and she said, "oh I've got half-brothers and sisters!" And I said, well yes, but *very loosely*. You would never call them a half-brother or a half-sister, they would just be *acquaintances*, but biologically...it's a little hard for her to understand.

Caroline raised the issue of the difficulty of knowing how to frame the relationships that might exist between her two daughters, and the triplets who were conceived by DI using sperm from the same donor. The two families had not yet met, though they now lived in the same city, and the question remained as to whether or when they might initiate such a meeting.

Sylvia was aware of a number of recipient families in the North Island who had taken the initiative to form relationships with other families with children conceived with sperm from the same donor. She said:

Sylvia: ...some couples, now more open about their involvement with DI, on seeing that they recognised similar characteristics about their children, chose to share their non-identifying information about their donors and indeed establish links. For example, one donor has almost without exception produced children with the most stunning strawberry blond hair. Two other families have daughters of very similar build, and these children discovered each other at the same ballet school. The resulting liaisons have been of mutual interest and satisfaction to those concerned.

The Donor Family Register was therefore conceived as a tool to help families with children conceived by DI to make connections with other families with children who were genetically related to them through the donor. The future of this register remains uncertain but its existence nonetheless raises important questions about the social meaning of genetic connections: the possible value of knowing which children are genetically related to one another as a means of avoiding consanguinous relationships, and the possibility of establishing kin-like relations.

### **Linking anonymous donors and recipients**

The processes by which donors are linked with particular recipients are generally framed as ‘choices’. For example, donors choose the categories of recipient to whom they are willing to give their semen, thereby controlling access to their semen. At the same time, recipients choose from a selection of donors, a choice that is nonetheless controlled by a number of intervening factors. Certainly recipients have not always had the opportunity to choose from a selection of donors and, in many cases, health professionals have played the primary role in ‘matching’ donors and recipients, thereby controlling the links between particular donors and recipients. According to Price (1997:221), ‘matching’ a sperm donor to a recipient was an important part of the culture of concealment in DI. Matching donors and recipient fathers on the basis of physical characteristics was done to enable the child to ‘pass’ as the genetic offspring of its social father (Price, 1997:222). According to Dr A, this practice has changed.

Dr A: I mean, initially you wouldn’t actually even let people choose the donor, you see. You’d say, “This one matches you.” (he laughs).

KH: And were they then able to choose because there were more donors, or because of the Human Rights Act, or what?

Dr A: Oh, it just seemed the right thing to do, you know. Because, I mean it’s difficult enough for *us* to decide what’s the right thing for them, and they might as well make the decision. They’re going to be just as right as we are (a brief laugh). I mean it does mean though that they do get to go through the whole profiles of a number of donors. There’s a potential risk to the donors’ anonymity by that. Well, you know, you can...the information is...if you knew someone you might be able to pick them up from that.

Dr A implied that recipients now have a measure of control over their choice of donor. But, of course, the choices they have access to have been controlled previously by those who recruit the donors and the donors’ choice to give to particular types of recipient. According to Dr A, allowing recipients to choose from a number of donor profiles presented a ‘risk’ to donor anonymity because it might be possible to identify a donor from reading his profile. This reveals the extent to which maintaining donor anonymity is a central organising principle, particularly between donors and recipients, even in the context of a DI programme that asks donors to be identifiable to potential DI offspring in the future.

A number of recipient couples included in this study said that were not offered a choice of donor. When asked if they chose their donor, Jane and Steve said:

Steve: No. ...the comparisons were done between the pair of us. They matched up between Jane and...

Jane: They told us, more so you than me. And I was trying to work out, well, how did they work that one out? I did find that quite questionable afterwards. "Oh, we've got the perfect one" and I thought, well how did you do that?

Other recipients who were not given a choice of donor suggested that they were just given sperm from straws of frozen semen that were available at the time. Joe and Ella, who had four children conceived by DI, claimed they did not have a choice of donor for their first two children. Joe said:

Joe: I think, for the first one, Dr A just got a straw didn't he? I mean it wasn't sort of "here's a profile of your donor," it was "here's a straw, let's go." Basically, that's what it boiled down to. They didn't have that many options. And we didn't particularly care either, to be honest.

This scenario highlights the constraints of choice imposed by a lack of donors in the DI programme and the doctor's decision to inseminate the recipient with whatever sperm was available at the time.

Like Joe, Tim, the father of a daughter conceived by DI, said he was not interested in choosing a donor, but his wife, Sarah, would have liked to have had that opportunity. They said:

Sarah: [At the clinic] they were just going to match hair and eye colour, so we didn't get donor profiles or anything like that. We had three goes. The first two were unsuccessful. On the third go they said would we like to choose our own donor. I probably wouldn't have minded looking at the profiles, but Tim, at the time, said "just let them choose."

Tim: Oh, I don't know. It's just too much of a hassle, I mean, eye colour and height and similar colouring is probably about it isn't it (he laughs) if you wanted to get a close match? You don't need to know whether they were a doctor, what their profession is, or anything else like that really.

Sarah: We were on the waiting list for 20 months, so, ah, it was a pretty long time, because back then they didn't have donors as readily as they have now, and I think on that last go they didn't even have any brown haired, brown eyed, but they said, "Would hazel eyes be OK?" and we just said, "Give us something that works" (she laughs).

Paul and Fiona, another recipient couple were also unconcerned about not being able to choose their donor. They said:

Paul: ...it was never really an issue for me anyway. I was just of the view that every person is an individual and to try and have some influence on it [choosing a donor] was sort of like tempting fate or something like that. I just sort of thought, well, they'd talked about matching eyes and matching hair colour and matching those sort of things and, as far as I was concerned, that was fine. The other thing was, even within families you've got such chalk and cheese differences

with the same parents, you know, that it always came back to, you could find someone who was...

Fiona: That you wouldn't think they were in the same family.

Tim's, Paul's and Joe's lack of interest in choosing a donor raised the question of whether the men were less interested in the donor than the women. New Zealand research into the attitudes and feelings of recipient couples with children conceived by DI showed that men were more likely than women to have negative feelings about the donor, know nothing about him and wish to know nothing about him (Gillett, Daniels and Herbison, 1996:140). This seeming lack of interest may, however, partly reflect clinical practices at the time: 'choice' was not framed as an 'issue' because it was not offered. It is possible, too, that having made the 'big' decision to conceive a child using donor sperm, some men consider the issue of who the donor is to be of minor significance. In contrast, for women, the use of a donor in itself might not be as important as who the person is, particularly as it is they who, in a sense, will be 'carrying the donor's child'. The question also arises as to whether infertile males are uncomfortable about the donor's role in the procreation of 'their' child. When I commented that perhaps knowledge of the donor served as a painful reminder for men of their infertility, Dr A had this to say:

Dr A: Oh, it is painful for some. Not all of them, some of them are reasonably involved, but even the most aware do have an avoidance factor. There are occasionally those who seem to be very interested, but I think it's more the woman that's interested. I'm not sure why that is.

Illustrating the contention that women were generally more interested in the donor than men, Kathy, a divorced mother of daughter conceived by DI, was uncomfortable with the lack of choice, and lack of information she received about their anonymous donor. She said:

Kathy: No-one gave us a choice, not at all. We weren't profiled at all well when I look at it. Back in those days there was talk that they did try to profile them as closely as they could to the parents and, in all honesty, they encouraged us to lie to the child and said "we want you to sign the birth certificate and basically no-one needs to know." That's what we were told on the programme. No-one needs to know. And I wasn't comfortable with that....so no, we weren't given any choices of donors....We were told he was a 6 foot, fair-haired, hazel brown-eyed doctor....I have since contacted them again and asked for further information which they were not forthcoming with at all.

Kathy was concerned that her child's looks and colouring were very different from hers or her husband's. Although uncomfortable with the secrecy surrounding DI,

Kathy had taken her husband's advice not to ask DI programme staff about their practices because she wanted to conceive a child.

In contrast to Kathy's experience, most recipients who had conceived through donor programmes more recently were able to choose their donor from a folder of profiles. A nurse working in a donor programme described the process of donor selection:

Nurse A: We have four profile books: one for married couples, one for de facto couples, one for lesbian couples and one for single women. This is because some donors will donate perhaps only to married couples, some will donate to everybody, so we have to respect their wishes. So, after they've had an initial interview, they've done their blood tests, and they're ready to start treatment, they make an appointment and they come and look at the donor profiles which are pertinent to them, and are given time to peruse that and they make a selection of two or three choices. So that, perhaps, if their first choice has his fourth pregnancy and he's unavailable, then we'll transfer to the second choice, and that's recorded in their file. So, they are in control of making the choice.

Nurse A highlighted the way in which the clinic constructs 'choice' for both donors and recipients. Donors are asked to select recipients on the basis of marital status and sexual orientation, and recipients choose a donor on the basis of a representation of him in the form of a text of 'non-identifying information'. Thus, recipient choice is constrained by donors 'targeting' categories of recipient, and by whether or not the chosen donor was still available.

Some couples raised the issue of the difficulty of choosing the prospective genetic father of their potential child from a profile containing non-identifying information. Alice and Peter commented that it was like choosing someone "from a catalogue". They said:

Alice: And we were told to pick three or four weren't we, because the ones we'd chosen might not be available. So we were able to choose within that time, weren't we? But I think that the first one or two choices we actually couldn't get because [the donor was not longer available]...

Peter: It was all a little bit unreal though, because the information was kind of, it was detailed, but it wasn't detailed enough. And so, it would have actually been really helpful to have a photograph (he laughs). I mean, the name isn't important, but a photograph would be useful in order to make the selection, because we're sort of pretty visual animals really. But I mean, it was reasonable that we didn't have a photo, I suppose, so we did it anyway.

Alice: A police identikit drawing could do (she laughs).

Like Alice and Peter, Petra and Jennifer, a lesbian couple, claimed it was difficult to conceptualise the donor as a particular person from the non-identifying information available. Petra said:

Petra: Because when we read the information, we said, “it sounds like so-and-so”, who’s a friend, who’s actually Olivia’s godfather. And then we said, “oh, but it also sounds like so-and-so”, who’s a bastard, you know. And so, you just get enough to join the dots and you could make several things out of joining the dots, so we tried not to.

In a similar vein, Caroline described the process of choosing a donor as “the most hilarious situation”. She and her husband Mike were grateful that the nurse in the DI programme actively guided them in their choice of donor. They said:

Caroline: From what I understand, now the nurses are not going to know the donors. They're going to be kept quite separate so they can't make preconceived judgements on who might be a better donor for a person. Whether or not that's a good thing or a bad thing, I don't know, but in our particular case I was quite pleased with [the nurse's] judgement.

Mike: Well, I mean, we had to make judgements out of a piece of A4 paper with words someone else had chosen to write, and you know what you can do with words. So we were rather thankful that someone had the ability to make a judgement based on more information than we had available to us. So I think it would be a big mistake to take that middle person out of the link.

Although Caroline and Mike valued the help of the nurse as an advisor in the process of choosing a donor, as previously discussed, recipients at this clinic are now required to make the choice on their own which has the effect of removing the responsibility from the clinical staff. A nurse working in a DI programme said that the process of choosing a donor was often at the end of a long day of consultations with clinic staff, which potentially created a pressured situation in which to choose. She said:

Nurse B: When [recipients] come in, I always say to them, if you want to have another look at your donor profile before we do this, or if you want to have another think about it, don't hesitate. More often than not, when they've made their decision they're happy with that. I think they just feel, well, come on let's get on with it. They've been on a waiting list for a good while. Why should they sort of hesitate now? Strike while the iron's hot. They know that it's not the exact replica of their partner. So, they just sort of do their best.

Many recipients who had the opportunity to choose a donor, opted for a donor with similar physical characteristics to their own; in particular, many couples sought to match the donor’s and the potential child’s father’s characteristics, so the father could ‘pass’ as the child’s genetic parent. Sean and Pippa, the parents of a daughter conceived by DI, had this to say about choosing a donor:

Sean: I guess the key thing would be somebody who looks close enough to me that it's not going to be startlingly obvious, and the second thing is somebody with similarities to me. The donor father is a headmaster...he's got vaguely similar interests to mine, so...

Pippa: We wanted somebody more like Sean, so Elspeth might have a similar...I don't know...have some similarities, maybe.

Choosing a donor who was similar to Sean lessened the likelihood of their child looking dissimilar enough to perhaps invite questions from others. Illustrating this possibility, Carla, a separated mother of a daughter conceived by DI, said:

Carla: ...[when] I got pregnant with Justine, there were only three donors [at the clinic], so there wasn't a heck of a lot of choice. And Justine's got beautiful big brown eyes, and both Ben and I are blue-eyed. We didn't even have a choice about that...We tried to match things physically, like the eye colour and that, because a few people have actually commented on that, people that know about those sorts of things. So that's been interesting. And with me raising Justine on my own, people have said to me, "Oh, the Dad must have brown eyes." And because we're not with Dad, they can't look. So it's easier for me to say, yes, I think he had brown eyes.

For some couples, the donor's height was potentially more of an 'issue' than eye colour. Alice, the mother of Erica, said:

Alice: One striking thing that has happened, actually, is that Erica has always been quite big. She's been 70<sup>th</sup> percentile and I mean I'm small, average, and I was always third smallest in the class, and there's some tall people in Peter's family, but the donor was 6'4". So it's very likely that she's going to be much larger than me, and people have been commenting all the way through about her height, and sort of often asking where it comes from.

While Alice and Peter had chosen a tall donor, a nurse working in the DI programme said that they generally lacked tall donors.

Nurse B: Another thing that we would like in our donors, I might as well put a plug in here, is that we would like them to be taller than about 5'8". We have a lot of short people who come through as donors and some people look at them. You know, for some people that's an important point. Look at this, and they've got a 6'4" husband, and here they've chosen a donor who's got similar colourings and things, but he's sort of 5'6" or something. And sometimes they will express that worry and I do my best to sort of go through meiosis and mitosis, and say, well these genes all get mixed up anyway. You could well have someone in your family who's quite short. Maybe it's the short gene that's picked up, you know, you can explain it in another way, rather than having to say, well, you know, this is a totally different child, if that's what you want to do.

Nurse B's "plug" for taller donors and her advice to recipients about managing 'difference' within their families highlighted the assumption that many parents want to conceal that their child had been conceived using DI.

Some couples said they each focused on different attributes in a donor. When asked what attributes they were looking for, Henry and Prue, the parents of two sons conceived by DI, replied:



Henry: Centre-fold of Cleo wasn't it, Prue, for you? (he laughs)

Prue: Oh, no. I was looking more for hair colouring, you know, just went for physical characteristics.

Henry: We tended to look for people with sandy hair or fair hair, but I was looking more at the interests of the individual. I wanted to see that they were doing stuff that I wanted the kids to do. So I was looking for the bloke who was doing stuff that I liked.

KH: What sorts of things?

Prue: I can't remember.

Henry: There was one donor that we talked about and turned down, and he was a fisherman, and he seemed like a good bloke, and I said, "Here's a good fellow." And she said, "No, he's too old."

In contrast to couples where the men appeared to know little about the donor, Henry recalled more about the process of choosing a donor, and about the characteristics of their sons' donors, than did Prue.

Whereas most heterosexual couples wanted donors with similar looks and/or interests to their own, and particularly to the male partner's, for Petra and Jennifer, a lesbian couple, matching their physical characteristics with the donor's was the least of their concerns. They were relieved to find only two donors to choose between and said:

Petra: We looked on that as a huge positive because the other thing that went through our minds with the donor insemination stuff, was we really didn't want to be Nazi about it. Like, in the UK you get height and eye colour, and I just think those are dreadful criteria for choosing a father on. So, we were really relieved that people had self-selected, and so if altruism and being open-minded are hereditary traits, then we already had those. You know, we wouldn't want a bigot to father our child, and we certainly wouldn't want Olivia to have to go and trace someone who would be going to say "Ick!" to her [expressing distaste], so they'd self-selected out, so I mean...

Jennifer: I think that it was really positive for me that Olivia's father positively selected a lesbian couple as being okay to have.

Petra: Yeah, it's a huge relief that if she goes and finds him later, he's going to be cool, hopefully.

Like Petra and Jennifer, several heterosexual couples stressed the importance of the donor's altruistic motivation to help an infertile couple, like themselves, have a 'priceless' child.<sup>38</sup> Richard and Belinda, parents of a daughter conceived by DI, Madison, said:

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<sup>38</sup> Zelizer (1985) argues that the 20<sup>th</sup> century has witnessed a profound cultural transformation in children's economic and sentimental value. In the earlier part of the century, children, who were once valued for their useful wage-earning capacities, became economically useless but emotionally priceless. Zelizer argues that, despite the financial costs of raising children in contemporary families, voluntary childbearing is an indicator of children's persistent emotional value to parents (1985:222).

Belinda: One thing that was really important to us was why he actually became a donor. And, this particular one that we have got now, his reason was his wife had infertility problems and they only actually conceived one child. And I thought, as a couple, that's a pretty nice thing to do, just go off and help others.

Richard: He was loving enough really to say, "Well hey, I'm able to help somebody out," and that's what Belinda said before, the reason for some of these donors donating is actually very genuine, and not just a matter of saying, "Hey, I'm getting paid a hundred bucks for this," because they don't get paid for it at all.

Some couples said that they chose a donor based on "global" rather than specific criteria. Alice and Peter said:

Alice: But we ended up choosing on sort of global things, didn't we, like personality, intelligence.

Peter: Achievements, academic achievements...

Alice: And interests.

Peter: Interests, sports and...we thought that the donor we ended up with actually was a little bit arrogant. He sounded a bit arrogant. But it's a little hard to tell, you know. Sometimes things come across, when they're written down, that certainly aren't intended that way. So, although that's always been a little bit of an inside joke for us, it wasn't a big deal.

For several couples, the donor's family medical history was an important consideration in the donor selection process. Mike and Caroline were interested to choose a donor with a good medical record. They recalled the donor they chose:

Mike: He had a good family health background. I understand that they all have but this one was not burdened with asthma or any of those things.

Caroline: Yeah. He didn't have that, and that was something we looked at - their health, whether they had asthma and things like that.

Mike: I'm not sure if people with those hereditary things can become donors. I honestly do not know. But I wanted to be sure that the limited information that we had indicated that his parents had lived to a ripe old age, that he didn't have any of these things that we would not want to introduce to a family.

Other parents had not received a great deal of information about the donor and would have liked to have known more about his family medical history. Sandra and Allan, had this to say:

Sandra: I think sometimes I'd like to know a bit more of their medical history, but then I guess we just trust the clinic that they went very thoroughly through that.

Allan: A donor is not someone whose parents had died early, or...

Sandra: Or had heart conditions, or diabetes, and those things.

Allan: So a lot of those hereditary things are screened out. So, you know, he might have been a better sire than I would have been. The only thing I did think of was, when I was establishing the pine plantation, I used to spray herbicides and I did wonder...you know you do read about all these Agent Orange, and all those sort of things. And I did wonder whether, in fact, that would have affected [his sperm quality].

Most couples did not receive a copy of their donor's profile until after their baby was born. Dr A said of this practice:

Dr A: We know which donor belongs to which pregnancy. We don't let couples take a copy of the information until they've got a baby. I mean, we let them look through it, but we try not to let them go away and write it all up. I can understand people wanting to remind themselves of what they've chosen, because it is a stressful thing to do. The difficulty about it is that they're looking at a number of donors and it may not be that donor that they end up using to get pregnant.

Illustrating that this could happen, one couple claimed:

Andrew: The only information we have about the first donor, we don't think is the right one. We don't have information on the right one.

KH: How do you know it was the wrong one?

Annie: Because I think there were four, and I'm not even sure how we got that, but I just know I'm pretty sure that that's not the right one. I had to ring [the nurse] and she was going to look into it, and hasn't actually got back to me. It was 18 months ago. I'm pretty sure that that's not the right one [she points to the donor profile]. I think, for the second child, we've got the right one.

Clearly, confusion can arise when couples who use a number of donors while attempting to conceive receive copies of donor profiles before a successful outcome is reached, and the profile of the donor who contributed to the conception is not clearly identified.

## Conclusion

This chapter has examined the discursive and relational strategies employed by three DI programmes in New Zealand<sup>39</sup> that set up relationships between sperm donors and recipients and between recipient families who have used the same donor. The chapter shows that in a process that is already medicalised, clinics also have power in mediating relationships between the various actors in the DI network. While these relationships are organised around the principle of anonymity, this is rendered more complicated by the policy adopted by New Zealand clinics to recruit only donors who are prepared to be identifiable to DI offspring in the future.

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<sup>39</sup> This includes Fertility Associates in Wellington, the clinic that piloted the Donor Family Register.

Analysis of interview material has illustrated the ways in which health professionals in fertility clinics act as gatekeepers and boundary controllers. It has identified the difficulties inherent in recruiting donors, and the stringent donor screening process that eliminates not only donors who are medically 'unfit' but also those who do not conform to an acceptable social profile determined by clinics at the local level. While DI programmes construct semen donation as an altruistic 'gift', unlike donated blood, it is strategically targeted to specific recipients through a selection process established by the clinics. This selection process illustrated the extent to which DI programmes seek to reproduce the traditional nuclear family, rather than 'alternative' family types, such as those headed by lesbians or single women. This, in turn, highlights the power of the medical profession to determine who has access to donor gametes, and what constitutes an acceptable family form.

Central to the analysis of the establishment of relationships in the DI network are issues of trust, choice, control and rights. Trust is shown to be as central to the medical encounter: medical professionals rely on donors telling the truth about their medical history, and recipients trust medical professionals to adequately screen and link them with an appropriate donor. Discursive strategies used by clinics to justify and shape their practices are the liberal discourses of 'rights' and 'choice'. Rights are sometimes complementary. For example, donors are considered to have the right to choose who can receive their 'gift', donors' partners have the right to be part of this 'targeting' process, and recipients have the right to choose a donor. Rights can also be seen to compete. Individuals conceived by DI have the right to have access to knowledge about their genetic origins should they choose to at some future date. However, donors have the right to remain anonymous if they did not consent to being identified at the time of donating. The fact that these choices or 'rights' are not written into law illustrates the tenuousness of such 'rights' claims, and the potential for conflict between various claims that could be made in the future.

Choices and rights, are shown to be constrained by those who have the power to define them. Many couples participating in this research were not offered a choice of donor and accepted whoever was chosen for them. While recipients are now given the opportunity to choose from a number of donor profiles, their 'choice' is nonetheless constrained by factors such as donor availability, and having to choose a donor from a

profile of unidentifying information because of the overriding organising principle of anonymity. As discursive strategies, choice and rights are also shown to be central to the implementation of forms of protection by clinics which do not want to be subjected to criticism or legal claims in the future.

With anonymity as the primary organising principle, the 'right' to access information about the parties to a DI conception is currently constrained and controlled by the health professionals at the local level. If, however, legislation is passed that requires the establishment of a central register of donor conceptions, this information, and access to it, will come under the control of a centralised administrative system. This raises important questions about who 'owns' the information about the parties to a DI conception and who should have access to it. Given that clinics play a pivotal role in setting up the relationships between donors and recipient families, do clinics have a possible future role as mediators between the families at a time when more people conceived by DI might wish to contact the donors? Should this information be readily available to recipient families so they are made aware of other children in the community who are genetically related to their own children? If so, how should this information be disseminated, and is there a role for clinics in terms of mediating initial contact between these families? These and other questions raised in this chapter are crucial to the development and implementation of policy and practice in DI.

## **Chapter Six**

### **The Politics of Access To DI Treatment**

Before the Human Rights Act came in in 1993, we weren't able to treat single women or lesbian couples, and it was our policy that we treated heterosexual couples in a stable relationship. And that was the policy. However, the law has changed, and we are not allowed to discriminate now. *Nurse A, a nurse working in a DI Programme.*

#### **Introduction**

This chapter examines the procedures instituted by two DI programmes in the South Island of New Zealand to manage access to donor sperm by prospective recipients. It illustrates that organisational strategies in clinics that are discriminatory in their effects can still be consistent with legislative openness in New Zealand in relation to marital status and sexuality. Through a cultural examination of the clinical context, the chapter reveals the ambiguities, complexities and contradictions that emerge as a result of the medicalisation of conception and pregnancy, processes that are generally constructed as means of 'forming' or 'creating' a family. In connection with issues of access, the chapter explores the barriers encountered by prospective recipients of donor sperm such as constraints on the availability of DI services and donor sperm, clinical policies and practices, and the financial costs involved. Also related to the issue of accessing donor sperm are the policies and procedures adopted by clinics to screen out those who are considered 'unsuitable' for parenthood. The chapter thus considers the ways in which fertility clinics are contexts for the construction of selves.

#### **Infertility diagnosis and referral**

Couples with male factor infertility were usually diagnosed by a general practitioner who subsequently referred the men to a urologist for further tests, or referred them directly to a fertility clinic. Neil said in relation to this process:

Neil: And the sperm result initially showed a very low level of sperm, and what...it might have been through Family Planning because, well, first, basically the first physical examination by the urologist - they should choose an easier name to say. He identified a lump, which he was concerned about, and in a very short space of time, like...well, "we'd like you to go in in two or three days time, and have an op to remove that testicle." He was concerned about cancer. So our focus switched from infertility to my health. And so that testicle was removed and another

sperm analysis and the count had dropped to zero at that stage. The tumour was benign and nothing has subsequently showed up during scans. ... The next step after that operation was for me feeling somewhat devastated and isolated in terms of my genetic past and future, because at that stage I had no knowledge of my birth parents.

Neil had trusted the urologist's ability to make a professionally responsible decision in his particular case. The urologist's detection of a tumour and the possible implications for Neil's health took priority over concerns about his subfertile status. Having had the testicle and tumour surgically removed, however, his fertility status declined in the sense that he then became azoospermic. Six months later, Neil and his wife Patricia, returned to Family Planning where a female doctor referred them to a fertility clinic.

Like Neil, Mike was referred by a general practitioner to a urologist before being referred to a fertility clinic. His positive experience of accessing DI treatment contrasted with his prior experience with the urologist. Mike said:

Mike: I had also been referred off to a urologist. He gave me an inspection and was quite...not flippant, but nonchalant in saying, "it feels fine to me but you know we could perhaps hang around with a scalpel and see what we could find", and I thought, "thanks a lot", but obviously to him it was not worth the effort. And that had a very negative effect on me. Plus, he was the professional and he said that the prospects of being able to do something, if there was something like a minor blockage, was quite, quite minute. He said, "you've got a very, very low chance of success". And to me that was negative. I don't know to this day what the reason for the infertility was. So I don't know. I'm left with that question. I thought for some time how would I react to having children that weren't genetically my own, but I think I got through that very quickly, and the fact that we had a very proactive GP, very good initial treatment from the fertility clinic, and you know, it was a brilliant atmosphere. There was a little board behind [the nurse] with photos of children. You could see straight away that you wanted to be in a position where we had children and that this was the only clear way that we were going to get there...at least for 50 percent of them.

Mike's situation illustrates the difficulty for specialists of delivering 'bad news' in a positive way, but also highlights the need for sensitivity on their part when relaying it. In contrast with his encounter with the urologist, meeting with fertility clinic staff was empowering in that it made him feel optimistic that, like others who had had babies through the DI programme, he could attain the identity of 'father'. Mike adopted a position as "consumerist" patient and "reflective" actor, actively calculating and assessing expert knowledge with the aim of maximising the value of health care services (Lupton, 1997a:374).

Like Mike, other recipients spoke of negative and unhelpful first encounters with medical specialists before they accessed DI services. Joanna, the mother of two DI children, had initially delayed DI treatment after visiting a gynaecologist. She said:

Joanna: First we went to [a gynaecologist] and he scared the living daylights out of me, so we didn't do it then. I'd heard lots of things about him, mad butcher, and whatever. That would have been 9-10 years ago, it was just the way he sort of approached me, and I think I was only young then. I was only about 23 then, and it sort of, yeah, it scared me then. But then when I was 25 we thought about looking into [DI].

Tania, the mother of a son conceived by DI, was critical of a doctor she encountered when she and her husband Mark were having their fertility investigated. She said:

Tania: We went to [a fertility clinic specialist] to start off. He was just awful. Then when we got Mark's results he said, "Oh, you cannot have a family, you'll have to have donor insemination", and shoved us out. No tact. So anyhow, we got put onto this lovely lady that does the inseminations. And it was up to us what we decided to do. Mark wasn't too keen for a start. So we looked at adoption and fostering and then decided we would do it.

By telling them that DI was the only option, Tania felt that the doctor positioned her and her husband as passive patients, rather than reflexive agents and consumers of services who could make up their own minds about how they would become parents (Lupton, 1997a). Joanna's, Tania's and Mike's criticisms of medical professionals were similar to those found by Lupton (1997a) in her study of lay people's attitudes towards the medical profession. Lupton found that participants tended to be highly aware of how a doctor interacted with them. They were inclined to judge doctors harshly if they felt that they had responded to them "in an 'uncaring' or abrupt manner, appearing insensitive to their feelings or not wanting to take the time to listen" (Lupton, 1997a:376).

### **Accessing 'treatment'**

Traditionally, DI programmes were established by medical professionals to provide a way of 'treating' heterosexual couples with male infertility. While medical discourse generally constructs DI as a 'treatment' for male infertility, Novaes (1992:10), has argued that reproductive technologies, such as DI, cannot be defined strictly as *therapeutic* in the sense that they 'cure' a physical ailment or disease. She argues that the concept of infertility is a very particular social construct in which medical and social criteria are closely interrelated (Novaes, 1992). Rather than describing a person



with a medically-proven problem of infertility, it describes a couple who is unable to conceive because one or both are infertile. In the medical ‘treatment’ of infertility, the ‘patient’ is always the woman because she is the child-bearer. Donor insemination highlights a paradox in the concept of infertility because it is carried out on a woman who is necessarily *fertile* and who could have become pregnant, if she had chosen to do so, by having sexual relations with another man. In this sense, this form of infertility (at least for the woman) is social rather than biological which disrupts the medical/social infertility binary when referring to couples with male factor infertility as distinct from lesbian couples and single women who are generally constructed as socially rather than medically infertile. According to Novaes (1992:11), rather than a way of restoring ill persons to health, the medical act of insemination is better conceptualised as an intervention to “alleviate more general conditions of personal distress”.

At the same time, medical assistance to conceive provides the technical expertise to achieve conception and also sperm from a medically-controlled gamete donor for this purpose (Novaes, 1992:10). In a sense, in the context of DI, medical professionals act as brokers of sperm to those who cannot provide their own, or who prefer to conceive with the sperm of an anonymous donor screened by a medically-sanctioned donor programme. Rather than ‘treating’ the cause of infertility, however, ‘treatments’ such as DI merely offer a way of circumventing infertility, providing the opportunity for infertile couples to conceive a child. Thus, DI operates as a form of medicalisation of family creation. In relation to this, Novaes (1992:1) has argued that assisted reproductive technology is more than just a technical exploit attributable to ‘progress’ in biology and medicine: “it radically alters the usual framework of corporeal practices and social relationships which organise and give meaning to reproduction” (1992: 1). Whereas conception is usually defined as the result of a sexual act by autonomous persons, reproductive technology transfers the act to the medical institution where relationships are generally defined in therapeutic terms and precedence is given to the quality, security and efficiency of the technical act (Novaes, 1992:1). Thus, achieving the conception of a child in the clinical context involves negotiations between social actors taking up a variety of subject positions and discourses of professionalism, mothering, gender, and family.

For couples with male infertility, DI may be the only way they can become parents. But to achieve this, prospective recipients of donor sperm generally have to surmount a number of barriers to accessing treatment. Crucial to the ability to access DI is the geographical accessibility of DI programmes and the availability of donor sperm. Several couples interviewed for this research had sought DI treatment in the mid-1980s, at a time when only one DI programme operated in the South Island of New Zealand. The director of the only South Island DI programme operating at that time said of the establishment of the programme:

Dr C: I think it began about 1980, '79 - '80 when donors were recruited in a more formal way, and patients had access to donors as well, but it really got well established in about 1983-84 when I [came back here], and also it coincided with the [other city] unit closing down with [the doctor providing DI services] leaving. So for about a two or three year period, we were basically the only South Island centre, so we did have a lot of work at that time...until about 1986, I think, '87, when the clinic was still basically a private clinic run by the [University]. It was not part of the hospital, or the infertility service as such. It was purely on a private basis.

Some couples who eventually conceived through one of the South Island DI programmes were initially referred to the other for treatment. Meredith said:

Meredith: My gynaecologist wrote a letter [of referral]. Well, we're talking about...it must have been 12 years ago [1986]. And we had several trips there, and every time we went to go, something would go wrong. There'd be snow on the road or something, and we couldn't get through. And then you'd have to make another appointment, which we'd have to wait months for again. And, it was really...it was quite awkward. And I had several tries down there. I used to have tests here and then rush down.

KH: Tests to see if you were ovulating?

Meredith: Mm. To see if it was the right time. Rush [there], and usually stay overnight I think. I only did that twice, and then they opened up here. But it took quite a long time from when [her gynaecologist] first wrote, to getting onto the programme. I think we had six months wait, and as I said, a couple of times we tried to get [there] and something would happen. And then they started here. And because I was actually on the [other clinic's] list and had started, I was first on the list [here]. So I didn't really have to wait here which was lucky. So, I carried on here.

Meredith's experience emphasises the significance of time and timing in treatment cycles. Visits to the clinic had to fit in with the clinic's schedule, her and her husband's work schedules, and the time scale marked by her menstrual cycle which became subjected to on-going monitoring and surveillance (Cussins, 1998a:91). Later, they were able to access DI services locally which was less complicated. Like Meredith and Karl, Joe and Ella were initially referred to the other South Island clinic. They said:

Joe: There was a little bit of blackmail involved, you know. They were doing a study, which involved, well you had to agree to the rules of the study or you didn't go on the programme.

KH: What sort of study was it?

Ella: Well, we had to go without intercourse for a month...was it a month or six months? Well, we were under enough stress as it was. And the travel, just the travel down there, and I probably would have had to have gone by myself...and just to go down there for nothing just for their study, I felt was a bit unfair.

Joe: Yes, you didn't just go for the insemination times, you had to go there for other times as well...No, we discounted it. Once we rang up and found out where we were here, we were going to finish up with her (he laughs) flat on her back quicker than if we had gone into the study in [the other city]. So we could actually fall into the programme here and achieve what we wanted to achieve quicker than in [the other city], so we just declined the opportunity there.

Joe and Ella's experience illustrates a tension between the interests of the clinic, which was seeking research data, and the prospective recipients, whose aim was to have a baby and thereby 'start a family'. It also illustrates Wasserman and Wachbroit's contention that assisted reproductive technologies have complex and often contradictory effects: they increase opportunities and prospects for women, while reinforcing their treatment as objects (1992:445).

Like Joe and Ella, Fiona and Paul found that they were able to achieve a pregnancy much more easily once they were able to access a DI programme locally. They had tried unsuccessfully to conceive through one South Island DI programme, but were successful after they were referred by their specialist to the local DI programme. They said:

Paul: It seemed to move on so quickly because it seemed to drag prior to that didn't it? It just seemed to go *on* and *on* and *on*, through our dealings with [the gynaecologist]. It just sort of got to the stage when we just thought nothing was happening...it was just month after month. It seemed, from a well-being point of view I think, particularly for Fiona, it just started to deteriorate really...the whole situation...and then once this started, it was almost, "gosh what's happening here?"

Fiona: It was just so easy just to pop into [the local clinic] rather than think, oh I'll get on the next plane [to the other city] or, you know, and just being monitored a lot closer [here was much easier].

Paul and Fiona revealed the significant ontological changes that couples experience when going through an infertility programme for a cycle or repeated cycles of treatment (Cussins, 1998b:170). At one time, a consumer of fertility services can be a person juggling their work schedule to be at the clinic. At another time, they can be a

generic patient in the waiting room, or sometimes ovaries and follicles on an ultrasound screen and so on. The clinical setting and the techniques used to achieve conception allow these ontological variations to be realised and to multiply.

Whereas couples like Paul and Fiona had had to travel to other cities to access DI services, others were referred to other clinics which had a better supply of donated sperm. Pippa and Sean said:

Sean: They referred us up to Auckland because there was donor sperm available there, and it didn't look like there would be in Wellington for some reason.

Pippa: So we went up to Auckland, didn't like the doctor up there, felt uncomfortable with him. I didn't like him at all. And it seemed quite difficult to tie it in with work and everything else. We were still thinking about it and it was kind of in the back of our minds. But then Wellington rang up and said there's a donor available. So that was a big relief really.

Sean and Pippa's situation illustrates the constraints placed on accessing treatment by the number of donors available in relation to the number seeking to access donor sperm. In relation to the numbers of people going through their DI programme, a nurse in a South Island clinic said:

Nurse A: We average about 20 couples a month, who we treat. Since the programme began we have treated over 400 people... we're up to about 413, I think, at this present time.<sup>1</sup> It varies from month to month depending on whether the people are away or what they're doing or whether they want a break from the programme, but it's averaging about 20 a month, and again that's depending on the donors available too. At the moment the numbers are slightly down because we have a smaller number of donors available and we can't... we only allow four families per donor. So we can't let ten women use the same donor per month in case they all get pregnant for example, so we have to limit them at the moment.

This clinic had a policy of limiting the number of families a donor could contribute to four.<sup>2</sup> As a result, they limited the number of women who could be inseminated with sperm from the same donor. For many couples, waiting to access treatment was a long, protracted process, even after they were accepted onto the DI programme. Ella, the mother of three children conceived by DI, said:

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<sup>1</sup> A newspaper article designed to recruit sperm donors stated that in the 12 years that this programme had been operating, 262 babies had been born through the use of donor insemination – 141 boys and 121 girls (Price, 1999).

<sup>2</sup> A reason for this was not given in the interview, and does not appear in the clinic's information sheet. But, Richard, a recipient who went through this programme said that they had been told that this limitation was instituted to mitigate against the likelihood of genetic half-siblings of the opposite sex meeting and forming relationships.

Ella: There's all this waiting...waiting to see a specialist, waiting to see this, and I had to go for a scan of my tubes, was it, before you could get on to the DI [programme]. And then you have to do an AIDS test. With the last baby...before we conceived him we both had to go for AIDS tests for some reason (she laughs briefly). And apparently you have to do counselling now, and stuff.

Ella's experience emphasised the objectification of the body in the medicalisation of reproduction. According to Lupton, "the body and its various parts are understood as constructed through discourses and practices, through the 'clinical gaze' exerted by medical practitioners". Thus, according to Armstrong, "a body analysed for organs and tissues is constituted by organs and tissues; a body analysed for psychosocial functioning is a psychosocial object" (cited in Lupton, 1997:99). Cussins (1998b) argues, however, that rather than being passive recipients of technological intervention, women actively accept the role of being the object of the medical gaze, participating in different kinds of objectification, with the knowledge that this may bring about desired changes in their identity. Thus, according to Cussins, objectification and agency can be co-constitutive in contrast to being oppositional (1998b:167).

While it could be argued that passing through these "ontological commitments" may embody new options for the long-term self (Cussins, 1998b:169, 170), couples accessing treatment through a DI programme had little control over the processes they had to pass through to achieve unguaranteed conception and the birth of a child. In some cases, the results of medical tests led to further delays in accessing DI treatment. Richard and Belinda said:

Belinda: The next hiccup was (she laughs) I don't have the...I think it's called...the Rh antibody, or some particular antibody. I don't have it, so it was important for the donor to have it. So two of the three [selected donors] got chopped, so we...

Richard: And the next one wasn't due to be cleared for a bit.

Belinda: Yeah. For about four months. So here we were, all set to go, and "Oopsy, sorry, can't come on the programme quite yet". Wait. So, I was waiting for this chappie to be cleared because he has to be frozen [the sperm] and cleared after six months to check for AIDS. As soon as he was cleared, I knew I was ovulating, and I rang them, telling the girls, "Hurry up with that chappie" (she laughs). And the poor chap was on holiday (she laughs) and they made him come in.

This situation illustrates the way in which the clinic acts as a genetic 'watchdog': because Belinda was tested for and found not to have the Rh antibody, she had to be 'matched' with a donor who possessed the antibody. While this is done to ensure that

children born as a result of DI are as healthy as possible, it nonetheless raises the spectre of medical control of reproduction and eugenics.

In another case, access to DI treatment was delayed by the recommendations of a social worker who, according to this recipient, was assessing the psychosocial functioning of prospective candidates for DI.<sup>3</sup> Meredith said about their encounter with the social worker:

Meredith: He gave us both a questionnaire and my answers didn't correspond with Karl's or something. Well we're...I think when you get married later in life you're more of an individual than if you get married young and you grow up together. We both have our own definite views, but it doesn't mean to say that you don't get on well. But he said that the marriage wasn't going to last, and he thought it wasn't a good environment to put a child in, on one meeting, which I thought was a bit strange. But he obviously had a job to do. He was sent to do it. He had these questionnaires to fill in and that was it.

Meredith and Karl resisted the social worker's evaluation of them, argued their case with health professionals in the DI programme, and were eventually accepted for DI treatment. This situation reveals a number of tensions between the social actors involved in the DI programme. While it demonstrates the power of the consumer to resist clinically-sanctioned screening processes, it also reveals a tension between the medical and psychosocial perspectives. It also shows that the medic is the ultimate 'gatekeeper' who has the power to over-ride the social worker's recommendations, and the power of medical professionals to ultimately decide who has access to fertility treatment (Novaes, 1992). Daniels (2000a) has pointed out that whereas clinicians tend to focus on patients and clinical outcomes, psychologists, social workers and counsellors are primarily concerned with the psychological and social issues connected with forming a family by DI, including the issue of the welfare of the potential child. It could be argued that in some ways this form of surveillance is more insidious than the medical watchdog. Medics know, for instance, that if the Rh factor is not present there will be problems with the pregnancy, the birth, or the child.

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<sup>3</sup> I have had the opportunity to speak to the researcher who was carrying out research on the psychosocial aspects of infertility and fertility treatment. He claimed that this research was not connected with any screening process in relation to accessing a DI programme. Nonetheless, some social workers and psychologists concerned with the psychosocial aspects of assisted reproduction have advocated the screening of couples before donor insemination to ensure that they meet "minimal criteria regarding their marital relationship, health and social adjustment" (Humphrey, Humphrey and Ainsworth, 1991:273). This position has been criticised recently by Walker and Broderick (1999a:41-42) who question the morality of this form of gatekeeping. The controversial issue of 'screening' recipients is discussed in more detail later in this chapter.

Social workers and psychologists, on the other hand, are on much less secure ground and their judgements much more at risk of prejudice or professional fashion.

Not all couples had a long wait to conceive by DI. Caroline and Mike felt that they were 'fast-tracked' through the DI programme. Caroline said:

Caroline: We got in very quickly, and I don't know how we managed to do that. But, we went and had the interview with [the nurse]. And we had said we knew we were leaving to go up to the North Island and that if we were able to, would it be possible to have treatment here since we'd started it here, and she managed to fast-track things for us, I think, quite quickly.

Unlike Caroline and Mike, a couple who requested semen from a Maori donor experienced delays in accessing DI treatment. This illustrates the difficulty of negotiating a particular ethnic identity in the context of DI programmes that primarily cater for, and who have access to, donors who are part of the white anglo-saxon ethnic majority. According to the health professionals interviewed for this research, South Island clinics tend to primarily cater for the New Zealand European population and do not regularly have donors from other ethnic backgrounds. One of the clinics, however, had had requests for Asian and Maori donor sperm, but was unable to supply it and, in one case, acquired sperm from an Asian donor in Australia (Price, 1999). When asked if they had donors from a variety of ethnic backgrounds, the person in charge of donor recruitment at a fertility clinic said:

Lab Technician B: We have very few [Maori donors] because we don't have many Maori down here. We have very few Maori...we've had the odd one. We have just recently had a Chinese [potential donor]...but because New Zealand has such a small Chinese community we don't really need [Chinese donors]. What we tend to do is bring [donor sperm for other ethnic groups] in from outside. And that's what we've done in the past, and that's what...I actually discussed it [with another staff member] and that was my feeling, but just confirming it, that really, the demand is not there for a start off and we tend to access sperm in these cases from somewhere else.

Helen and Patrick wanted to conceive with sperm from a Maori donor. Helen said:

Helen: It probably took six months to get [onto the DI programme].

KH: Because they had to find a donor for you?

Helen: Yeah, and that was from Auckland, and that took a long time. They were very limited in what they could offer. They had to do a swap of donor semen to get it. [The Auckland clinic] got some from down here. So there were two [donors] that we could choose from. And we picked the most appropriate.

Anecdotal evidence suggests that it is difficult to access sperm from Maori donors. MCART recommended that the range of donors recruited by clinics, especially those from minority ethnic groups, needed to be widened (1994:54). The extent to which Maori and other minority ethnic groups seek DI services in New Zealand is not known. According to an analysis of the submissions to MCART, many Maori favour the concept of 'whangai', a traditional form of adoption, or sharing of kin, as a means of addressing infertility in Maori (Dyall, 1999:36). Helen and Patrick had considered adopting a child from within Patrick's family but this was not possible at the time.

As well as initially encountering delays to accessing treatment, some recipients who wanted more than one child, and had had semen from the same donor allocated for this purpose, found that they did not have the option to decide *when* to conceive again. Belinda and Richard said:

Belinda: We said we'd just like one more, a playmate for Madison. But, I wasn't aware after Madison was born... I didn't understand that it's not until Madison is one year old that you're actually allowed to go back and try again....

Richard: They've got no control over that normally.

Belinda: They said, you've been through enough infertility struggle before you actually get this child, so now they are actually...they had to place some rules and regulations because it backfired on them before. ...What happened was a lady wanted another child, but she didn't [get her husband's consent]. She just went in and got another child, and consequently it broke the marriage up. So, they had to put some guidelines in and they feel that one year, you're giving...You actually have to go back through all the tests and sign all the consent forms again before we actually can try again...which is good. They've got to have...some input together. So we'll wait till Madison's a year old and then try for the playmate for her, because we feel two is better than one.

While Belinda accepted the rationale for the clinic's protocols, she nonetheless resented the loss of control in relation to deciding when she conceived a second child. The stipulation that one has to wait a year before accessing 'treatment' to have another baby does not appear to be applied in all DI programmes. Recipients accessing treatment in some North Island clinics said that this 'rule' had not been applied to them. This illustrates the way that regulatory decisions are made by clinical personnel at the local level in response to local events. Richard and Belinda's sister-in-law, Christine commented:



Christine: When Madison was about three months old, they got told that they can't go back into the donor system again until Madison is a year old, which struck me as being really cruel, because they had their options limited by Richard's problem anyway. So they couldn't choose when they wanted to have a child anyway. Now, they've got this child and they're part of this DI system, but they can't then choose again when they want to have one. They're still regulated with all this stuff, and it just...it actually really hacked me off, because I thought well, finally they've got this baby, and surely they should therefore then be able to just go on and decide like a normal couple when they want their baby, though of course they're using a third party to help with that baby. ... And they're like almost back to square one again having to wait...and then Belinda said they've got to go through tests and all sorts of stuff again...

Like Richard, Christine drew on a discourse of what 'normal' couples are able to do with regard to reproductive choices, arguing that they too should have this freedom of choice, even if a third party was involved in the conception process.

Some couples were not sure whether they wanted more than one child through the programme but, after conceiving a child with one donor, most couples had the opportunity to store sperm from the same donor for a possible future conception. Sperm from a specific donor is set aside for each individual couple who request it. Neil and Patricia, the parents of two DI daughters, took some time to decide whether or not to have a second child. They said:

Neil: I'm not sure when we first started to think about number two, but it was a long process of thinking and discussing with each other off and on, as to whether we wanted to have another child. Certainly the appearance of the storage bill from [the fertility clinic] for the sperm storage... Basically they were putting aside a certain amount of sperm from that donor should we wish to have further [children]. We paid for that storage, so every year when the bill arrived...will we keep it for another year or what?

Patricia: [We paid] \$120 a year. I think Tracey wasn't quite a year when we decided we didn't know whether we'd have any more, but perhaps we should set it aside anyway. We could always say well no we're not going to...and it hadn't deteriorated or anything.

The annual bill for sperm storage was a reminder to Neil and Patricia that they had yet to decide whether or not they would use it to conceive a second child.<sup>4</sup>

Not all couples were given the opportunity to choose to use the same donor for their second child. Joanna, the separated mother of two children conceived by DI, Todd and Jessie, said:

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<sup>4</sup> Information provided by a fertility clinic on semen storage indicates that semen can be stored for up to 10 years providing the annual storage fee of \$125 per couple is paid. Within this time limit, the couple can specify how long the sperm is stored in their name. However, according to RTAC guidelines (see Appendix D), donors are permitted to withdraw or vary the terms of their consent at any time, unless the gametes have not been used.

Joanna: We couldn't get Todd's father anymore. He wasn't on the programme anymore, which was a bit of a disappointment. It was very hard. When we were having Todd, not being horrible here, but they [the donors] were all like, doctors, accountants and everything, you know professional people, so you sort of had not much choice. But now, you've got more choice, like you've got a lot of shearers, farm hands. There's not many professional people, and we were trying to match up Todd's donor to our next child, so you know, they had the colouring, but also the same education, sort of, and we found that quite hard to match them both up.

Joanna indicated that although the choice of donor had expanded, their own choice was constrained by wanting to select another donor similar to their first donor.<sup>5</sup>

Having accessed DI treatment, some couples spent many years 'on the DI programme'. Joe and Ella, who wanted several children,<sup>6</sup> said:

Joe: I mean we were going... you know, we went there for six years?

Ella: Four children. I had them a year apart, so...

Joe: Really from '87 till '94.

Ella: You weren't allowed to go back onto the programme until the baby was a year old. So we just kept going back.

Whereas Joe and Ella had four children during the six years they were on the DI programme, Meredith and Karl spent eight years (two years on one DI programme and six years on the other) but had only one child as a result of recurrent miscarriage. Meredith said:

Meredith: I went for six years here. I kept going and going and going. I went for quite a long time. I had four miscarriages from here. And I kept going back again. I'd have a few months rest afterwards. But, that's why I was saying I can't speak more highly of the girls here, because if they hadn't been so nice and so good, I think I would have given up. But each time I had a miscarriage, [the nurse] would come and see me, or she'd ring up, or she'd be one of the first people there, saying, well, when you're ready, we'll have you back again.

Meredith finally gave birth to a son and was grateful for the support and encouragement she received from the DI programme staff who provided the impetus to keep trying until she achieved her goal of motherhood. This situation illustrates

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<sup>5</sup> It is interesting to note that Joanna refers to the donor as her son's 'father'. See Chapter Ten for a discussion of the ways in which donors are conceptualised and the language used when referring to them.

how the collusion between medical professionals and ‘patients’ serves to reproduce medical dominance (Lupton, 1997b:98). It also illustrates that medicalisation has unanticipated consequences: solutions to human problems (e.g. the use of DI to ‘treat’ male infertility) can often create new problems (e.g. Meredith’s experience of recurrent miscarriage) (Broom and Woodward, 1996:360).

### **The financial cost of treatment**

For fertility clinics, DI is merely one of several treatment options offered on a cost per cycle basis. Fertility clinics operate as profit-making businesses and provide price lists for treatment services offered by the particular clinic, including semen storage.<sup>7</sup> In 1998, the cost of a DI cycle was \$450 in one South Island programme and \$500 in the other. Although public funding has been available to a limited extent for IVF treatment, traditionally DI has not been publicly funded.<sup>8</sup> Dr A said:

Dr A: Traditionally there's never been any funding [for donor insemination]. I mean, when we set it up in [this city], there was quite a bit of political stirring about it from the then Hospital Board. Certain members of the administration didn't think it was a very proper thing to be doing, and there was a bit of...I've got a fair few letters that relate to that. I think some of them thought that to produce a semen specimen by masturbation wasn't very proper. So, I mean, those things have changed since then, that it wasn't quite the right thing to do. But, you know, the demand's still there. But it's not the best option for a lot of people, but it's a financial option.

By suggesting that DI was the “financial”, if not the “best” option, Dr A implied that they had other options (that also offer the ‘better’ option for men of becoming biological fathers) for those who could afford to pay for them. Dr A’s comments thus invoke the norm of the “ability to pay” which underlies access to most fertility treatments (Cussins, 1998a:73). Cussins’ (1998a) research in the American context showed that physicians in fertility clinics preferred to work with an “elite clientele” who could afford to pay for treatments, while nonphysician members of the team showed more concern about the exclusivity of fertility treatment.

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<sup>6</sup> This DI programme does not place a limit on the number of children recipient couples may conceive through the programme. However, health professionals stated that few couples have had more than two children through this programme.

<sup>7</sup> Price lists for ART procedures provided by the two South Island fertility clinics are located in Appendix C.

<sup>8</sup> Space does not allow for a detailed discussion of the complex and controversial issues related to access to public funding for fertility treatment in New Zealand. Recently, however, the Minister of Health announced that the Health Funding Authority had approved an extra \$3.7 million for fertility services, bringing total funding to \$5.8 million. This funding would include the purchase of, not only IVF, but also donor insemination and intrauterine insemination services (The Dominion, 2000; Letter to R Scott, Executive Officer, NZIS, from H Williams, Health Funding Authority, 3 August, 2000).

The cost of treatment was certainly an issue for a number of people interviewed for this research, particularly those on low incomes, or who had extended periods of treatment before conceiving a child. The counsellor working in one DI programme thought that financial considerations played a major role in decision-making about treatment options. She said:

Counsellor B: I think the financial part of it plays a huge part in the decision-making. And apart from the financial considerations, there is the time off work...so people are weighing all those things up, and the other major factor is that some people find IVF and ICSI quite an invasive treatment to go through physically, and they don't really want to go through that. Another important factor is how important each of them considers the biological link to be - for some people this is not so important, for example, those who already have a child from a previous relationship, and this can make DI a more appealing option than ICSI. But sometimes the factors that are influencing the decision are quite different for each member of the couple. So, it might be, for example, for men the financial aspect is really important, and for the woman the physical aspects might be important, which doesn't cause too much problem if it means they're both deciding in the same direction, but if it means they're each favouring something quite different...[conflict can result].

Male recipients in my research tended to make more direct references to the financial cost of treatment than did women. Some appeared to resent having to pay to have children, a process that 'normally' is free. Joe and Ella said:

Joe: The only thing is, it still costs the people individually money, when it should be free. It's not something you wish on anybody, and on top of it you have to outlay some cash because it's...It should be free I think from the government. Because it's low priority and people are willing to pay, there's no big...I mean, you get annoyed with it, but you pay because it's the only option if you want the children. So you just pay. You know, if you stood and fight you'd never have your children, so you don't waste your time fighting. You get pragmatic about it.

Ella: User pays.

Joe: Yeah, but it shouldn't have to be. That's what you pay your tax for, part of health services.

Joe's comments reflect a belief that fertility services should be available for those who need it, rather than on the basis of the ability to pay (Cussins, 1998a:73). This belief is at the core of infertility societies' political lobbying, both in New Zealand and abroad, for medical insurance coverage of infertility procedures and for the reclassification of these procedures from "elective" to "non-elective" (Cussins, 1998a:73).<sup>9</sup> In this way, so-called involuntary childlessness becomes classified as a medical problem in need of therapeutic intervention, rather than voluntary or

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<sup>9</sup> The New Zealand Infertility Society has lobbied for fertility services to become funded as part of non-elective services. However, a recent increase in funding of fertility services of \$3.7 million, which brings funding to a total of \$5.8 million, was determined by the Health Funding Authority on the basis that it was part of "core elective services" (Williams, 2000).

cosmetic. A problem with this, however, is that the conflation of infertility and childlessness restricts the frame of reference within which infertility is discussed (Franklin, 1990:221). According to Franklin (1990:221), “[t]he problem is defined entirely within the parameters of the traditional nuclear family, with the result that the only knowledge available about the experience of infertility is that which reconciles it with the expectation of social conformity”.

Like Joe, Andrew commented on the unfairness of having to pay to ‘have a family’, when most people do not have to. He and his wife Annie said:

Andrew: And it got more expensive. It cost us a few grand to do it. So we were committed to kids all right, financially. Other people just need to go to bed or look at the old fella, and they're pregnant.... Life's not fair.

Annie: We have one friend who gets pregnant really easily and accidentally, and they have all sorts of dramas about that, and we're thinking...[we should be so lucky] (she laughs).

For Andrew and Annie, the financial costs grew, especially in relation to having their second child, who was conceived on the 18<sup>th</sup> cycle. They raised the stereotypical argument that those who do not want (or who ‘should not’ have) children often do and those who really want children and would make ‘good’ parents, often cannot have them. A doctor Cussins interviewed suggested that those who could not afford fertility treatments were generally those who already had “too many” children. This, according to Cussins, invoked the stereotypical view that the population is divided between those who have too many children (for whom there is contraception, if they would only use it) and those who do not have enough (for whom there are assisted reproductive technologies, which they have to pay for) (1998a:73).

For some couples, the cost of DI was added to the cost of failed vasectomy reversals. Jane and Steve, who had previously hoped to conceive children without assistance, said:

Jane: We decided to go ahead with [DI] because, you know, that was the only chance we had because, um, it cost us...the whole reversal cost us all this money and you know, we didn't get it back.

Steve: It's a sore point, you know, it cost us \$3,000.

Jane: Yeah. What actually happened is, Steve had a reversal and they said there was a 50 % chance it would actually work, and it did. But the only trouble is, he's that good at healing, it healed itself all over again.

Steve: It shut down shop. The sperm count was up fairly high, up into the millions, and I was told by...I was under the specialist as well before that operation...and the results from that said that everything was all right at that time. Subsequently...

Jane: ...it healed all over completely [the vasectomy reversal]. It just actually decided to go and block itself off completely after the reversal, so then we had to...sort of had to look at...

Steve: Alternatives.

Jane and Steve's comments evoke an image of the 'fertile' body (i.e. having enough sperm) rendered infertile by a medical procedure (vasectomy) and attempts to reinstate fertility (through vasectomy reversal) thwarted by 'natural' healing processes. The couple constructed Steve's body as an active agent: his 'fertile' body became problematic and unruly, having "decided" to heal over the wound created by the vasectomy reversal, thereby 'sabotaging' the exit of sperm.

Some recipients said that cost was the major factor in determining the number of DI cycles they would have. Neil said:

Neil: My impression was that the second time around it was more pricey than the first time. I don't know...it might have been five or six hundred. It wasn't minimal. [Our limit was] six the first time around, but the second time around was a lower number. Yes, we weren't going to...we had a child and for me there wasn't so much hanging on [to have another]. You know, if it was going to be it was going to be, and I didn't want to invest a great deal of energy emotionally into that, and so that when Patricia conceived again, as far as monitoring the birth, no, well, we didn't want to invest a great deal of sort of focus on that.

Neil's comments raise the question of the relative significance of emotional as opposed to financial costs involved in DI treatment. Sarah said her husband Tim attributed his desire not to try for more DI children to the financial costs involved, but she was skeptical that this was the 'real' reason. She said:

Sarah: Tim kind of said it was a monetary thing, but it wasn't really. What he was trying to say is I just don't think he can go through that bullshit again. With people saying, "Oh, you got pregnant" you know, and it's just another thing of...I mean, I have to read between the lines when he's talking about money, because we made a decision really early on that we'd never talk about money and children in the same sentence, because it was very offensive to me. And then when he started talking about it, it was, like, he wasn't really talking about money, because we are in a far better position now that we were back then.... What he was saying was I don't think I can go through it all again, Sarah. I'd really love you to have another baby, but going through the whole process again is a reminder, and we've got our children, you know, and then as it was, so, I had to make the decision. So when the renewal came up, I just sent it back to say no thank you.

Like Sarah, Mary, the mother of two children conceived by DI, did not want to relate the cost of paying for DI services to how much her children were 'worth'. She said:

Mary: Once there was something on TV and they were talking about the costs of donor insemination and all the rest of it. And [her son] piped up...I don't know how old he was...and he says, "How much did it cost when you had me?" And I said, "I can't remember." There's just no way (she laughs) I was gonna put a cost on him. There was no way I was going to say anything to him, so I said, "Oh I can't remember." I thought, well that's just terrible for him to say that, but they were just saying that it's about \$3,000 a turn or something, and it was just on a TV programme we were watching.

Brendan: [When we did it] it was cheap. I think we paid about \$40 didn't we?

Mary: (she laughs) Yeah. I was going to say two thousand.

Mary had conceived her son at a time when services were cheap relative to current costs,<sup>10</sup> and particularly in relation to other treatments such as IVF. She possibly thought that \$40 might have sounded a little too cheap: \$2,000 sounded a more 'respectable' price in terms of a child's 'worth'.

For those on low incomes, the financial cost of treatment took on a particular significance. Like Neil and Patricia, Helen and Patrick decided to limit the number of cycles they had the second time around. Helen said:

Helen: We had a rough calculation of what it cost us to have Thomas, and with loss of wages combined it was \$10,000. But we were both working and it wasn't a problem. We were paying \$350 a month plus accommodation, plus six days lost wages. So it was a big outgoing. [For the second child] I had to save up and I saved up \$700, and I said to Patrick, we can only have two goes. That's it. And I said, we could stretch to three, but I said, after three we can't afford it. We can't financially ruin ourselves. And we can't take away from Thomas just for a want [wanting another child]. And I got pregnant [with Connor] on the first go. I remember writing the cheque out.

Helen raised the issue of other costs involved for many people undergoing DI treatment, including travel, accommodation and lost wages.

While Helen and Patrick lost wages for a few days, others lost significant income by leaving paid work to concentrate on becoming pregnant. Meredith, who suffered several miscarriages while on the DI programme, said:

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<sup>10</sup> This indicates that the cost of one DI cycle had increased over twelve fold in as many years. This illustrates the extent to which reproductive medicine has become a business enterprise in its own right, rather than a 'side-line' to the main business of obstetrics and gynaecology.

Meredith: I used to go along and have [injections to prevent miscarriage]. But then I still miscarried, and that was worse, because the miscarriage took weeks to happen because I'd had these injections to try and hold onto it. But you see, so the fourth time I got pregnant I didn't know what was going to happen. But I went back onto these drugs, these injections again. So I thought I'd try them again, and oh, by this time I wasn't working either. I'd given up work so I could just [concentrate on having a baby]. I think I had about two or three years when I didn't work.

Meredith's situation highlights the experience that the costs involved in DI treatment are financial, physical and emotional, particularly when treatment extends over a period of some years. It also raises the spectre of the problematic, but otherwise 'healthy' body, disciplined by (expensive) hormone injections in the bid to make it conform to the "normal" pregnancy trajectory (Cussins, 1998a:75).

### **Access to DI by lesbian couples and single women**

Donor insemination programmes in New Zealand were originally established to enable heterosexual couples with male factor infertility to conceive. Other groups, however, such as single women and lesbian couples have requested access to DI, but in the past were often denied access on the basis of their marital status or sexual orientation (Daniels & Burn, 1997). As outlined in Chapter One, the passing of the Human Rights Act, in 1993, meant that single women and lesbians could no longer legally be denied access to DI services.<sup>11</sup> But access by these so-called "minority groups" remains controversial in New Zealand (Daniels & Burn, 1997). This controversy illustrates Wasserman and Wachbroit's contention that reproductive technologies have complex and contradictory effects: while increasing opportunities for the creation of traditional families, they also enhance prospects for alternative family forms (1992:445).

To attempt to gauge public opinion on whether or not "minority groups" should have access to assisted reproductive technologies Daniels and Burn, in conjunction with Heylen Research Ltd., carried out an opinion poll (1997). From the results, they concluded that "a majority of New Zealanders feel that lesbian couples, single women and couples where women were past the age of menopause should NOT have access

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<sup>11</sup> According to Daniels & Burn (1997:80), the Human Rights Commission Act, 1977, made unlawful discrimination on the grounds of race, colour, ethnic or national origins, sex, religion, and marital status. In 1993, the Human Rights Act extended these grounds to include disability, sexual orientation and family status. Discrimination on the basis of age was introduced in earlier legislation (Daniels & Burn, 1997:80).



to AHR services” (1997:83). As they point out, however, these opinions were in conflict with those of the Human Rights Act 1993, the 1994 Ministerial Committee Report on ART, and the Interim National Ethics Committee on Assisted Reproductive Technology (Daniels and Burn, 1997:83).

According to Daniels and Burn (1997:80), the most common fertility treatment sought by lesbian and single women is DI. In line with reported public opinion on this issue, a number of fertility clinics have shown a reluctance to provide fertility services for persons who do not fit the criteria of couples with male factor infertility (MCART, 1994:54). The committee notes in its report that many fertility clinics “hesitate” to provide services for lesbian women, but argues that, as the law stands, providers must not discriminate on the grounds of sexual orientation (MCART, 1994:55). The report also stipulates that research evidence does not suggest that children raised by lesbian couples are at any greater risk than those brought up by heterosexual couples (MCART, 1994:55).<sup>12</sup>

MCART appeared more wary of single women gaining access to AHR services claiming the existence of evidence that “single parent homes are financially far less secure than two parent homes” (MCART, 1994:56). In its opinion, children born to solo mothers are potentially more “at risk” than those brought up by two parents. The committee therefore argues that if a clinic was not satisfied that a single woman could provide “proper care” for the child, they would not be in breach of the Act if they denied services to that woman (MCART, 1994:56). While the Act clearly states that it is not possible to deny access to a class of persons, it is possible to deny access to a particular couple or persons on the grounds that they do not meet particular standards of suitability for parenthood.

In relation to many other countries, New Zealand legal/regulatory practices are quite liberal in terms of allowing access to DI services by single and lesbian women. According to Blank (1998:143), most countries that have some sort of regulatory practices around DI do limit access to married couples or heterosexual couples in a stable relationship. This is the case in Sweden. In France they limit access to stable

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<sup>12</sup> For further research evidence see, for example, Golombok and Tasker (1994), Brewaeys (1997:100), New Zealand Law Commission (2000:133).

couples where the male is sterile or has a genetic disorder only. In Italy, only married couples are accepted for DI. Although single women are not precluded from access to DI in Denmark, co-habiting couples are given priority. In Australia, legislation in Victoria limits access to married couples only,<sup>13</sup> while South Australia restricts access to married couples, or de facto couples if their relationship has lasted at least five years (Blank, 1998:144). According to Blank (1998:140-141) only Spain, the United Kingdom, and New Zealand appear to allow access to DI by 'single' persons, though it may also occur to a limited extent in Canada and the United States.

According to Golombok and Tasker (1994), lesbian women had been denied access to DI in the United Kingdom on the basis that they would not provide an "appropriate home environment" for the child. This is because the child would have two mothers, would be genetically unrelated to one of the mothers, and the donor would be unknown to both. In relation to single women seeking DI, concerns had been expressed that it was potentially harmful for a child to be born to a single woman who was not intimately involved with a man (Golombok and Tasker, 1994:1972). Several health professionals interviewed for this research expressed concerns about knowingly assisting in the creation of what some have labelled "fatherless families".<sup>14</sup> Many appeared to be guardians of established understandings about what constitutes a 'family', drawing on discourses about the superiority of the traditional nuclear family. At the same time, they had to work in a context where state regulation was shaped by new liberal discourses about non-discrimination. A nurse working in one DI programme said that she was concerned that the focus of DI treatment had shifted from treating 'medically' infertile couples to 'socially' infertile single women and lesbian couples.<sup>15</sup> She said:

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<sup>13</sup> A recent decision (28 July 2000) by Justice Sundberg in the Federal Court of the State of Victoria, Australia, however, stated that the marriage/de facto marriage requirement of the Infertility Treatment Act 1995 was inconsistent with section 22 of the Sex Discrimination Act 1984 and inoperative by reason of s 109 of the Australian Constitution. This means that having a husband can no longer be a requirement of those sections of the Act. This decision therefore allows for access to fertility treatment by women without male partners (ITA, 2000:1).

<sup>14</sup> As discussed in Chapter Two, and illustrating the controversy surrounding providing DI services to lesbian and single women, the clinic that facilitated my access to most of the recipient couples participating in this research denied access to lesbian couples who had conceived through their DI programme. Moreover, they informed me that no single women had conceived through their programme. The lesbian couple I subsequently interviewed for this research, who conceived through this DI programme, was accessed through personal contacts.

<sup>15</sup> 'Medical' infertility refers to a physiological impairment that prevents conception; 'social' infertility suggests an inability to conceive because of a woman's lifestyle choice that precludes sexual

Nurse A: Before the Human Rights Act came in in '93, um, we weren't able to treat single women or lesbian couples, and it was our policy that we treated heterosexual couples in a stable relationship. And that was the policy. However, the law has changed, and we are not allowed to discriminate now. So, we have a number of single women and lesbian couples wanting treatment.... Our donors are exempt from discrimination because they are making a donation, so they have the right to say where their semen goes. Now, because of this, we have at the moment one donor available who will agree to have his semen used with single women and lesbian couples, so it's a simple supply and demand problem. We usually say to them if you wish to bring in your own donor, and that would help alleviate the problem, and they have to go through the same screening process as our donors, through sexual health, counselling, and that would alleviate the problems. But what society is generally saying to us, is that a lot of donors aren't comfortable with their semen going to single women and lesbian couples. So, that, in itself, is a problem.

Nurse A appeared to project her own concerns about helping lesbians and single women conceive onto “society” as a whole and onto donors who, she said, were generally not comfortable donating their semen to these women. This view reflects the findings of the Heylen poll on the attitudes of New Zealanders to access to AHR services by minority groups (Daniels and Burn, 1997). However, the question arises as to whether the type of donors recruited also tended to reflect the general culture of the clinic which, to a great extent, is shaped by the values and attitudes of the clinical director and those who work for him or her. Moreover, if these ‘categories’ of recipient were not presented to donors, how many would volunteer “no single or lesbian women”? When asked if he had qualms about ‘treating’ lesbian or single women, Dr A said:

Dr A: Ah, oh I suppose, emotionally, I probably do, on a personal level. But you know, I can also find plenty of justification that that's not quite...you know, if you look at these people, they often have a wide network of support and things like that, and we do try to work out what sort of support networks they have. I certainly feel very uncomfortable...we don't allow people to become pregnant and then go on to the Domestic Purposes Benefit. Now, that may or may not be justifiable within the law, but certainly the donors that we have are not keen on that concept. And I can understand their concern. We don't actually have any donors who allow that to happen. But the difficulty is you have to take everybody on face value. You have to believe what they tell you, and I mean, my whole life revolves around trust. And occasionally you find that what people are telling you is not quite what the reality is. But you can't send out the police to check people out and things like that.

Like Nurse A, Dr A indicated that it was the donors who controlled who had access to DI services. They had the ‘right’ to decide who could have access to their sperm;<sup>16</sup>

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intercourse with a male partner. As discussed earlier in this chapter, however, while women with an infertile male partner are considered medically infertile, because of their partner’s infertility, strictly speaking women who undergo DI treatment are ‘socially’ infertile because their reproductive capacity is necessarily unimpaired, and they can conceive with a different, fertile partner.

<sup>16</sup> This is in line with the Ethical Guidelines on Assisted Reproductive Technology published by the Australian National Health and Medical Research Council (NHMRC) which stipulates that “the gamete

and since most preferred to assist in the creation of conventional, rather than unconventional forms of family, their wishes prevailed. Dr A's discomfort about assisting conception in those other than heterosexual couples with male factor infertility, might also relate to the lack of legal recognition of families led by lesbian couples. Issues relating to the status of same-sex relationships and families led by same-sex couples are currently being debated and addressed by New Zealand Parliament. The Law Commission, which has produced discussion documents on this matter, has requested public submissions on the issues.<sup>17</sup> A recent report by the New Zealand Law Commission, published in response to submissions on adoption law reform, states:

A significant number of lesbian couples are resorting to donor insemination in order to have families together. In these families one mother is the biological and legal parent of the child, while the "other mother" has no legal status. The usual practice is for the co-mother to apply to become an additional guardian. This position is not considered satisfactory by many of these women, as they feel that their children are not adequately protected by the law (New Zealand Law Commission, 2000:209).

Other staff working in the fertility clinic had qualms about treating single and lesbian women. Counsellor A was particularly concerned about access to DI by single women. She said:

Counsellor A: Most of the people are really good value people, and would make really good parents, but yes, I do have qualms. I'm not value free. I think that's a little naive to expect. And I do enter into debates with single women, a conversation, bringing up issues of "my only worry" and I say it like that, "That is my concern"...is these children without fathers, invisible fathers. And they usually say that there are a lot of solo mothers around, and I usually say, well, yes, but generally they know where they are. "He was no good. He hoofed it to Sydney." or "Oh, he's in [prison]" or "We don't have much to do with him. He lives in Auckland and he's got married again." There's usually a story. There's usually that bit of the jigsaw. ...So, that's that bit of identity that that child has got. Even though he's absent, there's a story there. Whether or not it's a good story, there's a story there. But I do have worries about children being created with no father. I worry for them, and I'm concerned about the store they put by meeting a donor.

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provider, and any spouse or partner of that person, must give consent to the keeping or use of any gametes..." (1996:6). RTAC guidelines for screening for gamete donation (see Attachment J in Appendix D) guidelines stipulate that "[d]onors should be given the opportunity to direct or limit the use of their material to certain categories of recipient, for example heterosexual couples, or specific cultural and religious groups."

<sup>17</sup> The New Zealand Law Commission has recommended discussion of four possible options: (1) amending the Status of Children Amendment Act 1987 to give legal status to planned lesbian-led families; (2) allowing lesbian couples to opt into the presumptions set out in the Status of Children Amendment Act, (e.g. by applying to the Family Court prior to undergoing donor insemination), rather than having the presumptions apply automatically; (3) state that same-sex couples in this situation must apply for step-parent adoption, (which has been allowed in Denmark, since 1 July 1999), or an enduring guardianship order; and (4) maintain the status quo, which would need to be considered in the context of the child's best interests (Law Commission, 2000:211-212).

In response to such concerns, Golombok and Tasker (1994) conclude that while systematic studies of children conceived by donor insemination to lesbian or single heterosexual mothers are lacking, existing research on lesbian or single-parent families does not indicate that these children would be at risk of psychological problems. Currently, in New Zealand, the Law Commission is in the process of revising adoption laws. In its most recent report, which includes reference to public submissions on the issues, the authors recommend that single persons and same-sex couples should not be prohibited from applying to adopt a child (New Zealand Law Commission, 2000). It remains to be seen whether these recommendations become law.

Counsellor A was particularly concerned that some single women were seeking to have children in their late thirties because of their “inability to form relationships” and that their primary motivation to have a child was to “fill the void in their lives”. She had fewer qualms about lesbian couples becoming parents through the DI programme. She said:

Counsellor A: The lesbian women I haven't got so many qualms about because they have chosen a lifestyle without men and they have a relationship.... They're very intelligent people that we have through, and they've got quite broad attitudes. They, they're not rampant exclusive sort of lesbian couples. They're quite integrated people who have chosen a lifestyle because of genetic, biological, social, psychological reasons, and they do it knowingly. That this is a lifestyle they've chosen. It doesn't invalidate other lifestyles, and yeah. And there are two of them in a relationship. And of course they use a donor programme. They've chosen not to have relationships with men.

Also exhibiting qualms about the suitability of some single women for parenthood, a nurse working in the same DI programme expected that single women would find it difficult to cope raising a child on their own. She drew on her personal experience of raising a family and her reliance on her husband's support. She recalled the single women who had been through the DI programme:

Nurse B: There's one or two who've come through who I would have no qualms about at all because they've got big extended families and you meet half the family during the process of getting pregnant, and you just know that they will have...they will be fine. There's people everywhere who will give support, but there are others who, um, you know the odd career woman and so on, I think, goodness, what is she going to do when she's not flying around the world, or not doing this and that and the other thing? I mean, you've got a stressful job, and you're not as young as you used to be, you know. Because they're sure to be stressful,

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kids. So as far as personal feelings with single people in particular managing their children, it does worry me, and I do feel personally that it would be the very best to have both male and female on site.... Professionally, I have no qualms at all about them.

Nurse B's comments revealed significant ambivalence about helping single women to conceive through the programme. Although she claimed not to have qualms about dealing with them on a 'professional' level, she nonetheless was worried about the implications of women raising children alone. She shifted between a discourse about the traditional family and the division of labour, and a new discourse about reproductive rights. Ultimately, for her, childrearing was a collective activity for a woman and her extended family, or for a couple, but not a single person alone. Nurse B had anticipated feeling most uncomfortable about dealing with lesbian couples, but had not found that to be the case in practice.<sup>18</sup> She said:

Nurse B: I thought that I would have worries treating lesbian women. I thought that I might find that an issue, but in actual practice I haven't found it an issue at all.

KH: How many would you actually have coming through though of single women and lesbian couples? Is it a very small percentage?

Nurse B: No it's not a small percentage at the moment. It's not. They would be the most. Yes, yes. We've had four or five lesbian couples who have got pregnant over the last couple of years. I felt that there was a network somewhere, which I assume there is, and that we've had...we seemed to get a whole batch, seemed to get a whole lot all at once, and that was sort of a little bit mind-boggling. But, however, you know, you manage.

Nurse B seemed to indicate the numbers of lesbian and single women coming through the programme were the most that she had seen. Her ambivalence about treating lesbian women is clearly articulated: on one level she found it was not "an issue" but on another she found the number of lesbian women coming through the programme to be "mind-boggling". She drew on discourses about the 'inappropriateness' or 'weirdness' of homosexual women conceiving and bearing children and the need to accept that these women also had a 'right' to access fertility services, which was more in keeping with contemporary concerns about 'political correctness'. The situation illustrated the conflicts that emerge between professional and personal discourses, and that this has to be managed within the professional context.

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<sup>18</sup> A newspaper reported that lesbian women were "put off" seeking medical treatment from homophobic doctors. The Medical Association chairwoman, Pippa MacKay, was reported to have said that she was disappointed, but not surprised, by prejudicial treatment of lesbians by health professionals because doctors were "human, and behave humanly" and could not help sharing society's

The views of the health professionals working in this clinic appeared to be reflected in the number of pregnancies achieved by lesbian or single women through this DI programme. Dr A said about these two ‘categories’ of women:

Dr A: In terms of clinical entities, the lesbian couples are different from the solo women in that you're actually more likely to get pregnancies in a lesbian couple than you are in a solo woman. That might sound strange, but the lesbian couples generally are a bit younger, whereas the solo women are usually women who for various reasons currently don't have a partner and don't see one, and realise that life is beginning to leave them by, and usually then they're in the older age group. Therefore, you know, age is a thing that affects fertility. So that we don't have...I mean, we have equal pressure from both those groups for availability of semen.

When referring to single and lesbian women, Dr A appeared to distance himself from them by calling them “clinical entities” whose presence created a “pressure on the system” because so few donors were willing to donate their semen to them.

When asked about the process of gaining access to DI treatment through this programme, Jennifer and Petra, a lesbian couple, said that the process was reasonably “straightforward”. Nonetheless, they encountered some resistances which were different from those that heterosexual couples encountered because of the social and legal ambiguities surrounding the status of same-sex couples and lesbian-led families in New Zealand. Like several other couples, Jennifer and Petra were on a waiting list for about six months before they were able to access DI treatment. Jennifer said:

Jennifer: I was referred by my gynaecologist. I'd been under a gynaecologist for a number of years for a previous condition and I spoke to him about our wish to have kids, and explained our circumstances and he said, “well, you tell me when the time's right for you, and I'll refer you to the fertility clinic.” So that was straightforward, and we got a letter from them saying we were on a waiting list and there was a waiting list for six months.<sup>19</sup>

Although Jennifer and Petra's referral and acceptance on the waiting list for DI treatment was uneventful, they found it more difficult to access sperm from the same donor for their second child, which Petra planned to conceive. They said:

Jennifer: It's worth saying that that was an issue for the clinic, and when we initially said it, after I conceived with Olivia and said that we wanted sperm put aside, they were wanting to

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prejudices. Nonetheless, she cautioned doctors not to convey their personal feelings on homosexuality to patients (The Press, 3 August, 1999).

<sup>19</sup> Six months is not an unusual waiting time. A nurse working at this DI programme said that ideally they liked to keep the waiting list to three months but, because of the shortage of donors, the wait was currently eight months.

consider Petra as a separate family. Because every donor can only be used for four families, they wanted Petra to be as a separate family and to go onto the waiting list or whatever, and we argued that, no, we were actually one family and that was when...

Petra: Because we'd only be using the same amount of sperm as if Jennifer had all the kids.

Jennifer: And it was an issue that the clinic hadn't actually thought through, so we went back to see [the counsellor] and that's when we actually met her, and talked it through with her, and basically, together we wrote a letter to [the programme director], saying the social reasons why it was an important issue for the family cohesion and all those kinds of things. And, it was accepted. We got a letter back from [him] saying they would reserve sperm for Petra.

Petra: But, you see, now we're not sure if they've classified us as two families, because...

Jennifer: On the letter from [the director] it said, "But this will actually limit the number of other families who can actually use this particular donor", which made us think he'd actually treated us as two families.

This situation raises important sociological questions about what constitutes a 'family' and who has the power to define it. It demonstrated the tensions that exist between the clinical definition of what constitutes a 'family' and Jennifer and Petra's view of themselves as a 'family'. It emphasises the medical view that women are the focus of treatment and each family can have only one child-bearing woman, or mother. This view also reflects New Zealand law, which is currently under review, that recognises the biological mother as the only legal parent of the child, though the co-mother can apply to be an additional guardian (New Zealand Law Commission, 2000:209). Jennifer and Petra had argued that, for social reasons, they constituted one family but, although the DI programme director eventually agreed to set aside sperm for them from their first donor, he indicated that this precluded another family from having access to that donor's sperm. This indicated that, according to the clinic's policy framework, the two women and their children constituted two separate families.

In contrast to the views expressed by staff at the above-mentioned DI programme about assisting conception for lesbian couples and single women, staff in the other South Island DI programme did not specifically mention that they were concerned about offering a service for single women and lesbian couples. The director of the DI programme volunteered that being a lesbian or a single woman constituted a clinical 'indication' for DI treatment. He also suggested that "about half" of the donors at this clinic were willing to donate semen to single or lesbian women.<sup>20</sup> Counsellor B

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<sup>20</sup> It should be noted, however, that the notion of "about half" is vague, especially when no actual numbers have been given. According to the nurse working in the same DI programme, because of the



indicated that she had no qualms about lesbian parenting, but that lesbian parents and single women had different ‘issues’ to contend with than heterosexual parents. She said:

Counsellor B: There would be some different issues for [lesbian couples]. Who's going to carry the baby? The partner who is not carrying the baby can feel quite left out of the process. That's normal, but it's important to acknowledge that and think about ways of dealing with it. There are all kinds of issues about how they can help their children handle difficult reactions of other people. Also things like what they're going to call themselves. None of the couples I've seen have made a decision about that but we have talked about it. It's their own to define really. They don't have to follow any kind of pattern for that. And issues about what family members say and what kind of reactions they've had from talking about it with their family and their friends.

With respect to single women seeking to conceive through DI, Counsellor B said:

Counsellor B: I think it's very important for the woman to have a lot of stability and support in her life, to be able to manage juggling work and going through pregnancy and having the child...I would want to make sure that the child was not in danger in any way, [she later wrote on her returned transcript: “which is not to say that I think children born to single women are any more “in danger” than those born to couples”]. I guess one of the main things I'm trying to do with all the people is trying to think about the rights of the potential human being, which is not easy to do. And all of us are trying to figure out what it would be like for the potential child. Some people are really good at thinking about the issues for the potential child, and often they use the analogy of being adopted if they have had, or know others who've had that experience themselves, or if they've had a foster brother or sister or any of those kind of things. That makes it easier to imagine what it would be like for the potential child.

Counsellor B, a fairly recent graduate, was representing dominant discourses about reproductive rights and family diversity. Rather than intimating that children born to single women or lesbian couples were more ‘at risk’ than those born in traditional families, she focussed attention on the different issues that both lesbian and single women had to address. In particular, she focussed on the hypothetical issue of the ‘rights’ of the potential child. Counsellor B’s position makes an interesting contrast to that of Nurse B, who was caught between discourses about what constitutes the ‘ideal’ family, and new liberal discourses about reproductive ‘rights’, ‘choice’ and the acceptance of diverse forms of ‘family’.

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usual drop-out rate when screening donors, they had only a small number of donors who had been cleared who were willing and available to donate their semen to single women and lesbian couples. As a means of comparison, a brief item in a women’s magazine indicated that 30% of donor sperm stocks at Fertility Associates in Auckland (a North Island fertility clinic) were used in the insemination of single or lesbian women (Grace, 1999:39). Again, actual numbers of donors that contribute to this “30%” of stored donor semen are not reported.

### Screening Recipients

While sperm donors recruited by the two DI programmes officially submit to a rigorous 'screening' process, the screening of recipients, that is, deciding whom to include or exclude from treatment is a much more circumspect and informal process. This is primarily because if clinics were to refuse treatment to any prospective recipients, they would have to be able to justify their decision before a legal forum, such as the Human Rights Commission, and demonstrate that they were not unfairly discriminating against the recipients concerned.<sup>21</sup> Daniels and Taylor (1993b:1476)) argue that, in the New Zealand context, providers of AHR services have considerable discretionary power in the formulation of selection policies for access to fertility treatment. General criteria for acceptance onto a DI programme in New Zealand, have included subjective factors such as stable relationship, happily married, and sound mental health (Daniels and Taylor, 1993b:1477). Criteria relating to marriage have been omitted, however, after the passing of the Human Rights Act 1993. When asked if the clinic had specific criteria for excluding recipients from accessing DI treatment, the Director of one of the two South Island fertility clinics said:

Dr A: We don't have...I mean, we do have criteria in that we don't have any semen available for people who would not be able to support their babies themselves, so that in itself is an exclusion criteria. We...I mean, if we have qualms about somebody, it actually makes a lot of work because you have to justify that to them, and usually you give them your reasons why you think, and often if they're motivated enough, they will go back and look at it and try and change things, and we've had someone recently who just didn't seem right. But we gave reasons why that was, and then she went and documented for us all those sort of things, and it seemed...sometimes those people come through a different GP to their own GP and that's always a little bit of a disturbing thing because why is it that the other GP is not referring them? So, I think we act sensibly and in a caring but concerned way.

In the UK, under the Human Fertilisation and Embryology Act 1990 (United Kingdom, 1990), general practitioners are asked for information on patients who have approached a fertility clinic for treatment, specifically in connection with the issue of the welfare of the child (HFEA, 1999). Under the terms of the HFE Act, clinics

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<sup>21</sup> Coney (1999d:41-42) cites two complaints brought to the New Zealand Human Rights Commission in relation to access to assisted reproductive technologies from persons claiming that they had been discriminated against on grounds of sexual orientation or disability. In each of these cases, the complaint was upheld and treatment subsequently accessed. Similarly, in Australia, it was reported that the Queensland Antidiscrimination Tribunal had ruled that a lesbian woman should have access to donor insemination. The woman had been denied treatment on the basis that she was a lesbian (The Press, 1.2.97). Another more recent court decision in Victoria, Australia, (28 July 2000) in the case of *McBain v State of Victoria & Ors* has resulted in lesbian and single women being granted access to infertility treatment (ITA, 2000).

offering treatment services must take account of “[t]he welfare of any child who may be born as a result of the treatment (including the need of that child for a father)... (HFE Act 1990, section 13, 5)” (HFEA, 1999). The HFE Act does not exclude any woman from treatment, but in situations where there is no legal father, clinics are asked to pay particular attention to the mother’s ability to cater for the child’s needs throughout childhood (HFEA, 1999).

A nurse working in this DI programme said that they generally did not turn people away if they lacked financial security, but that the clinic policy was not to create babies so mothers could go on the domestic purposes benefit (DPB). She said:

Nurse B: The single women that we have coming through are older because they’ve managed to build up some form of either a career, or they’ve got their own homes, because that’s something that [the counsellor] looks at quite carefully to make sure that they could actually maintain a child and that it would have a stable home environment. So, more often they own their own homes, or they live with a brother or something like that. But there’s sort of a home ownership attached, and um, so that does perhaps limit some people, I don’t know.

Nurse B indicated that most of the single women accessing DI services were financially independent to the extent that they were home-owners. It could be argued, however, that while home ownership implies residential security, it does not necessarily imply financial security because of the on-going need to meet mortgage repayments. Nurse B’s comments raise the spectre of discrimination based on socio-economic status at this clinic. She conceded that some women might need to go on the DPB for the period including the end of the pregnancy and the first year of the child’s life, but that most had arranged with their employers to have time off work, before returning to full or part-time employment. Thus, it appeared that single women were asked to disclose information about their financial means and their on-going ability to support a child themselves.

When asked about selection criteria at the clinic, Nurse B said:

Nurse B: We don’t seem to have any criteria for exclusion, unless there seems to be a history of perhaps potential violence, or if they...the only one that I can think of is one person who...one couple who were declined and that was because...the guy already had one child, they had a donor child and that donor child...was it the playgroup or kindergarten supervisor I think it was, or somebody like that who had had dealings with one of the other children who felt that they weren’t really very well looked after. They would arrive not completely dressed and there was obviously stress in the household, and I don’t think that they were...it was very difficult for them to find...to live, let alone to have children, let alone to have another one, although they badly wanted it. And, this was a long time ago, and [a nurse] was there then, and um she had had quite a long chat to this woman on her own and felt that it was really the guy who was trying to get her to have another child. And that she couldn’t

really deal with another child...not coping at all well and she really didn't...but because he was being rather persistent and, you know, we're not sure of other behaviours that might have been going on. And it was sort of feedback from these other people.

We had to write to their kindergarten and there was somebody that we'd written to...they'd kept changing doctors...and we'd been in touch with some of the other doctors. You know, we really had to do quite a bit of work to find out just what was going on as best we could, and Dr A in the end wrote and said that he felt that it would be...from the information...we had to ask their permission to sort of speak to the playcentre person, and you know, those sorts of things. And so Dr A wrote and said that he felt that under the circumstances they might be best just to sort of leave it in the meantime. And we haven't heard from them again. So that was tough.

Nurse B indicated that, as well as acting as gatekeepers, the clinic staff at times took on a more active role in surveillance which included reference checks on individuals whom they were uncomfortable allowing access to donor sperm. In this case clinical staff determined that the welfare of the future child would potentially be compromised.

Counsellor A maintained that although she was not officially 'assessing' prospective recipients, she nonetheless recorded any concerns she had. She said that she would be concerned if people presented with poor psychiatric or physical health. According to Daniels and Taylor (1993b:1477), many have suggested that the same criteria as those applied in the case of adoption should apply in relation to accessing AHR, including "physical health and emotional stability of both partners, good marriage relationship, acceptance by both of infertility, and a genuine fondness of children for their own sake". The question arises, however, as to how one determines whether a couple has a good marriage relationship, or is fond of children (Daniels and Taylor, 1993b). In the UK, Humphrey, Humphrey and Ainsworth-Smith (1991) argue the case for "screening" DI recipients as opposed to "vetting", which implies a more searching examination. These authors contend that candidates for DI should be expected "to satisfy minimal criteria regarding their marital relationship, health and social adjustment" (Humphrey, Humphrey and Ainsworth-Smith, 1991:273).

Counsellor A raised the issue of the potential difficulty of evaluating prospective recipients on one meeting because there is no way of ensuring that they were being

open and honest about their situation.<sup>22</sup> She raised the prospect of ‘unsuitable’ recipients potentially ‘slipping’ through the system if they ‘performed’ well during the interview. She said:

Counsellor A: Occasionally you get people who inadvertently fall into telling you something that...like I said to one couple who were really special class material. But they were doing quite well in the interview too. I said, “have you considered adoption?” They said, “no, they wouldn't have us, they wouldn't have us in adoption.” “Oh, they wouldn't have you in adoption? Why is that?” “Oh, he nearly killed a bloke and he's got a prison sentence as long as your arm...they'd never have us.” And I said, “well our concerns are very much the same as the adoption agency.” And thank God they did come up with that because they got into a worse stew later on in my obstetric career by kidnapping someone's baby...a young woman they had sort of seduced into their company, a young single woman, and they went off with her baby. So they wouldn't have been very suitable.... But they might have slipped through, Katrina, if they hadn't said that.

Dr C raised similar concerns about prospective DI recipients. He said:

Dr C: The counselling role is really just an assessment role, a supportive role, and also for giving information. If there's any concern then it comes back to the team. The whole team really gets involved, but then again, it doesn't happen that often. We have turned down some people in the past, and I can't remember some of the reasons why at the moment. For example, there's a couple seeking assessment at the moment where it was very obvious at the first interview that it wasn't going to be easy because they didn't seem to have an understanding of the process. The male partner had a low IQ, measured at 60 or 70 when he was a child. I knew that from his notes. [Physical problems] associated with obesity, and he is still very morbidly obese now. His partner, his wife is an epileptic and has a low IQ as well. So, they are currently undergoing a psychosocial assessment. That is an example where it would be difficult for us to decide whether there are grounds for turning them down. You know, I mean, if any couples are going to be turned down, I suppose it could be them, but I don't know.

Dr C constructed the role of counsellor as that of assessing, giving support and information, rather than actively screening or gatekeeping.<sup>23</sup> He did not provide specific examples of those who were denied access to DI treatment but, like Counsellor A, he provided an example of a couple who were potentially not ‘suitable’ candidates for treatment. He, nonetheless, indicated that he was uncertain whether this couple would be turned down which illustrates clinician circumspection about declining access to DI, or being seen to decline access, in case the decision led to costly litigation for the clinic for Human Rights infringements.

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<sup>22</sup> As previously discussed some authors have questioned whether a counsellor or psychologist can adequately assess a client's suitability for parenthood through donor insemination in one or two meetings (see, for example Walker and Broderick, 1999a:42)

<sup>23</sup> See Chapter Seven for a more detailed discussion about the role of counselling in fertility treatment programmes.

The question arises, then, as to whether or not a more formal screening process should take place before couples are accepted into DI programmes. A nurse at one of the DI programmes argued that perhaps, like adoption agencies, DI programmes should have access to more information about recipients seeking to become parents. Nurse A commented on the desirability of developing some sort of selection criteria for recipients which enabled clinics to objectively have more power to determine who has access to DI services. She suggested that this was “fair” considering the extent to which prospective adoptive parents are screened by adoption agencies and donors are screened by fertility clinics. With regard to the screening of adoptive parents, in the New Zealand, the purpose of adoption is to provide a child who cannot or will not be cared for by his/her own parents with a permanent family life (New Zealand Law Commission, 2000:68-72). With respect to adoption agencies’ screening of prospective adoptive parents, according to Coney (1999d:47), one of the central tenets of New Zealand family law is that the interests of the child are paramount.<sup>24</sup> Thus, when placing a child for adoption, prospective adoptive parents are screened to ensure the welfare and the best interests of the child are met.

By contrast, in the case of access to assisted reproductive technologies, fertility clinics offer services to ‘infertile’ persons (mostly couples) who wish to conceive and, barring gestational surrogacy arrangements, bear a child themselves. In this situation, it is argued that because under ‘normal’ circumstances a couple can conceive, whether or not they meet particular criteria, those who seek medical assistance to conceive a child should be treated similarly. In particular, clinics must comply with human rights laws and not discriminate on grounds covered by such legislation. However, there may be grounds to deny access on an individual basis if the welfare of the potential child is considered to be “at risk” (MCART, 1994:56). Questions arise, however, as to how such judgements are made and who has the power to determine them. The Ministerial Committee (MCART, 1994:59) suggests that making such judgements is not easy – it is a “delicate and imprecise art” which calls for wider consultation and the development of guidelines.

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<sup>24</sup> Section 43 of the Guardianship Act 1968 states that “...the Court shall regard the welfare of the child as the first paramount consideration. The Court shall have regard to the conduct of any parent to the extent only that such conduct is relevant to the welfare of the child” (Coney, 1999d:47).

Criteria for assessing the suitability of couples for DI have been set in the past. For example, Stewart, Daniels and Boulnois (1982) report on the development of a psychosocial approach to artificial insemination by donor (AID) and the need for psychosocial assessment by a team including a social worker, a clinician and a psychiatrist. The team developed criteria based on an assessment covering five areas: duration of the marriage, stability of the marriage, personal characteristics, social functioning, and understanding of, and commitment to AID. While these criteria for assessment were applied in the 1980s, in the current social, political, and legislative context, some would be considered discriminatory, overly intrusive and unacceptable.<sup>25</sup> MCART (1994:50-51) points out the enormous shift in New Zealand societal values over the past few decades, characterised by the development of human rights instruments and a widespread campaign against various types of discrimination.<sup>26</sup> The Committee also alludes to the growing societal understanding that the notion of “family” is not limited to the traditional “nuclear family” (MCART, 1994:50)

Given the existence of human rights legislation to protect individuals from various forms of discrimination, and the seemingly growing acceptance of a plurality of family forms in the New Zealand,<sup>27</sup> the development of any formal criteria for screening participants is fraught with difficulty. In the absence of specific guidelines or legislation in this area, clinics are left to establish their own informal selection criteria (Coney, 1999d:41). These criteria are based on the values and beliefs of those who have the power, in that particular local context, to determine who can acceptably be permitted to conceive and thereby form a family by DI. Coney suggests that this is an area of valid concern (1999d:46). She cites Hamed’s contention that those who are

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<sup>25</sup> These included the following criteria: only married couples were to be considered for DI; lesbians were denied access to DI; judgements were made about how stable or otherwise a marriage appeared to be; the psychological and social functioning of the couple were assessed; applicants where one party was over 40 years old were excluded; and couples were assessed for their ‘acceptance’ of their infertility (Stewart, Daniels and Boulnois, 1982:855). According to Ken Daniels, three of these five criteria are still applied in most clinics that have protocols. Those specifying that the recipients must be married no longer apply.

<sup>26</sup> Specific human rights legislation in New Zealand includes the Human Rights Commission Act 1977 which instituted grounds for unlawful discrimination on the basis of race, colour, ethnic or national origins, sex, religion, and marital status (which was undefined). The law was revised with the passing of the Human Rights Act 1993 which added the new grounds of disability, sexual orientation and family status. Age had been added slightly earlier (MCART, 1994:50).

opposed to certain categories of persons accessing AHR services use the concern for the ‘rights’ and ‘interests’ of the child to mask prejudice against those who do not meet conventional standards of who ideally should be parents (Coney, 1999d:46).

The issue of screening for access to fertility services remains controversial and presents an on-going challenge to policy makers and health professionals working in the field of assisted human reproduction. It is the most controversial area in the counselling field with different disciplines, including psychology and social work, taking different views.

## **Conclusion**

This chapter has focused on the ways that medical professionals in fertility clinics manage access to the scarce resource of donor sperm. It illustrated the extent to which staff working in two New Zealand DI programmes engage in activities involving gatekeeping and surveillance in the process of determining suitability for parenthood with the use of DI. Analysis of interviews with recipients and health professionals showed that achieving conception in the clinical context involves negotiation between social actors taking up a variety of subject positions and discourses of professionalism, mothering, gender and family. People’s varying experiences in accessing treatment illustrated the diverse processes by which identities are constituted and negotiated in particular settings.

While DI is not strictly a medical ‘treatment’ or therapy in the sense that it cures a particular ailment, i.e. infertility, it nonetheless offers couples with male factor infertility a way of achieving the identity of parent and forming a family. While it is men’s bodies who are ‘at fault’, it is women’s bodies who are ‘treated’ and subjected to the medical gaze during the process of bringing about the desired changes to their identities. During this process, couples, and women in particular, experience a series of ontological changes. The chapter has therefore illustrated that fertility clinics are contexts for the construction of selves. Would-be recipients of donor sperm are positioned or position themselves variously as research subjects, objectified bodies,

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<sup>27</sup> Despite the reality of a diversity of family forms in New Zealand society, the minority of which conform to the ideal of the “nuclear family”, it could be argued that the latter is still considered the preferred family form and the norm to be aspired to.



people juggling work schedules so they can travel to the clinic, psychosocial objects, generic patients in the waiting room, people with particular ethnic identities or marital or socio-economic status, and so on. While clinics have traditionally treated those who are deemed to be ‘medically’ infertile, since the introduction of human rights legislation, clinics are not permitted to discriminate against categories of persons, including those who are deemed to be ‘socially’ infertile. While many health professionals had personal qualms about creating ‘fatherless’ families, they nonetheless had to perform their work in a socio-political environment where it was not possible to openly deny access to treatment to these persons. At their discretion, however, clinics are legally able to deny access to treatment to individuals or couples they determine to be unsuitable for parenthood.

While fertility clinics have no formal criteria for the exclusion of certain categories of persons, they nonetheless would generally exclude prospective recipients with certain characteristics, such as a propensity to violence, the inability to support a child financially, poor psychiatric or physical health or ‘coping’ strategies. The issue of applying specific selection criteria to those seeking AHR services is controversial. While adoption agencies have the power to access criminal records and ‘vet’ potential adoptive parents, for couples seeking to conceive and bear a child themselves, the same policies do not apply. At the same time, many who wish to access DI services may find their choices are constrained by a system controlled by health professionals who, while working within the law, ultimately have the power to determine who is and who is not able to conceive by donor insemination.

The chapter has shown that regulatory decisions are made in clinics at the local level in response to local events. This had particular implications for parents who were not able to choose when to conceive or have the opportunity of procreating children who were full siblings. In determining who has access to sperm, and under what conditions, health professionals in clinics appear to have significant power to define what it means to be a ‘family’ and who is deserving of creating a family. This links to wider and on-going debates about what, in fact, constitutes a family and who should have the power to define it.

## Chapter Seven

### Negotiating Clinical Worlds

I thought for some time how would I react to having children that weren't genetically my own. But I think I got through that very quickly, and the fact that we had a very proactive GP, very good initial treatment from the fertility clinic, and you know, it was a brilliant atmosphere. There was a little board behind [the nurse] with photos of children. You could see straight away that you wanted to be in a position where we had children and that this was the only clear way that we were going to get there...at least for 50 percent of them. - *Mike, father of two daughters conceived by donor insemination*

#### Introduction

This chapter examines how couples negotiate the shifting and changing identities of 'client', 'patient' and 'potential parent' as they inhabit the clinical worlds of the fertility clinic. It begins with recipients' 'induction' into the DI programme, the information they are given by nurses, medical directors and counsellors about conceiving by DI and the possible implications of choosing this method of conception. The differentiated subject positions taken up by staff working in fertility clinics are explored. The clinical worlds of DI are gendered worlds where women generally take on the role of carers in a nursing or counselling capacity and men of medical doctors and decisionmakers. The role of counselling in the clinical context is considered in light of some of the ambiguities and debates that exist in connection with this aspect of infertility services.

Couples' experiences of inseminations and achieving conception are also a focus of attention. The chapter also examines couples' experiences of pregnancy and birth after DI conception. While the role of the clinic officially ends with the establishment of the normal pregnancy trajectory, participants reported some contact between recipients and clinics. This raised questions about the possible need for followup, particularly for parents who have on-going issues in connection with conceiving and forming a family with the use of DI.

## Beginning treatment<sup>1</sup>

Having accessed treatment on a DI programme, often after waiting for several months, prospective recipients receive information about the DI programme from their respective clinics.<sup>2</sup> The nurse in one DI programme described the information sent out to recipients before they began treatment.

Nurse B: We usually send them an information sheet. It's just a skeleton outline really. It talks about the procedures. It talks about how to get onto the programme. It talks about the blood tests that they're going to have to have done and why. And again, [the clinical director] goes over these things in his interview, and I think probably [the counsellor] talks about them as well. It talks about how to do their LH testing. It talks about... again, it's written down that we think it's a wise plan to tell the child of its origins. The costs are written down, and phone numbers for contact and all those sorts of things. That's the DI information sheet. They're also given a sheet on cycle monitoring which helps to detect when they're likely to be ovulating so they can work out either from their calendar at home, or something before they start thinking about cycle regulation.

As discussed in Chapter Six, invariably it is the woman's body that is being 'treated'. Thus, the woman needs to become knowledgeable about her 'natural' reproductive cycle<sup>3</sup> which, in turn, becomes a 'disciplined' cycle through monitoring and surveillance. As well as practical information on diagnostic and treatment protocols, this clinic also indicates its philosophical position on the child's 'right' to know its donor origins.<sup>4</sup>

Initially, couples seeking treatment through the two DI programmes studied for this research met with a clinical specialist, a counsellor and a nurse, each of whom had a specific role or focus within the donor programme. As in many other hospital settings, a gendered division of labour was apparent. Men held the positions of power in the hierarchy as fertility specialists, programme directors and ultimate gatekeepers to treatment, and women were positioned as 'carers' in the roles of nurse, counsellor, behind-the-scenes scientist, or laboratory technician (Cussins, 1998a:83-84). Daniels (2000a:11) argues that the inclusion of counsellors, psychologists or psychiatrists as a matter of course within fertility treatment programmes in New Zealand represents a paradigmatic shift "from the simplicity of the 'medical model' to the more complex,

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<sup>1</sup> I have chosen to dispense with using inverted commas here because medical procedures using assisted reproductive technologies are commonly referred to as treatments, even though, as discussed in Chapter Six, they do not conform to the usual definition of a medical treatment.

<sup>2</sup> Information sheets provided by fertility clinics are located in Appendix C.

<sup>3</sup> In addition, the woman's cycle may be stimulated by drugs such as clomiphene.

<sup>4</sup> This important issue in connection with conception by donor insemination is considered in more detail in Chapter Nine.

multi-factorial, holistic, biopsychosocial approach". According to Schwartz, "the biopsychosocial model proposes that medical diagnosis should *always* consider the interaction of biological, psychological and social factors in order to assess a person's health and to make recommendations for treatment" (cited in Daniels 2000a:11, original emphasis). Daniels argues that the inclusion of 'counsellors'<sup>5</sup> on the fertility treatment team has been fostered by a growing recognition of the social dimensions of assisted reproductive technologies (2000a:11). In his view, those with counselling skills can offer a psychosocial<sup>6</sup> perspective in this field which other health professionals are not trained to offer, nor are these issues the primary focus of their attention in the clinical setting (Daniels, 1993, 2000a).

After being accepted for treatment through a DI programme, prospective recipient couples generally met first with a clinical specialist to determine the best treatment option. The director of one DI programme said that he sometimes sent couples to the counsellor to ensure they were better informed about the wider implications of choosing a particular treatment option before they signed treatment consent forms. He said:

Dr A: I like to do consenting after they have had a chance to talk, particularly with [the counsellor], because she's actually so good and got so much information to give them. And that process gives them time to think, and often when they're with [the counsellor] they express a different view than by the time they come to me when they've thought it through, and things like that. So that sometimes they come to me and I'll refer them to [the counsellor]. If they come from another doctor who has discussed it and they've looked at it and I believe that they've got good information, then I often would get them to see [the counsellor] first within the same week of me seeing them for consent and things like that. So, it's not an absolute situation. If I feel that it's important they get information then I'll see them first to help in their decision making. Because there's nothing worse than them coming along and they think they probably don't want donor insemination and go and see [the counsellor] and discuss it (he laughs). So you just have to take that as it comes.

To some extent, Dr A tailored the process of recipients' pathway through the clinic according to how prepared they were for giving informed consent to submitting to particular diagnostic and treatment protocols and practices (Cussins, 1998a:75). He recognised the usefulness of the counsellor in terms of her ability to provide

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<sup>5</sup> Daniels (2000a:13) states that counselling services vary a great deal in the field of AHR. Counsellors in ART teams, he claims, may be drawn from a number of disciplines including social work, psychology, psychiatry, pastoral counselling, marital and family therapy, medicine, and nursing.

<sup>6</sup> The term psychosocial can be defined as "of or involving the influence of social factors, or human interactive behaviour" (*The Oxford Dictionary and Thesaurus*, 1997).

information that helped clients make decisions about their preferred treatment option.

Counsellor A said of her role in the the intitial stage of the treatment process:

Counsellor A: It would be great to see some [recipients] earlier. ...Dr A might say...but it's changing now with ICSI and PESA...might say to them, well we have got a donor insemination programme, and they might be thrown into disarray by that, and you know, just feel as though they need a space to talk about that, or even feel they need a space for him, or them as a couple, to come to terms with the fact that natural parenthood for them might be a little elusive, without high tech help, or donor help. So, I might see them at that stage before they've come onto any programme at all. But that's not the usual way I see them. Usually they're about a year down the track from diagnosis, and they're coming for their appointment with Dr A, so they come to see me first, but I might only see them once. So, yes, I do do decision-making and fertility counselling with some, but the majority come for their one session, which is mandatory.

Counsellor A indicated that three-quarters of recipients became pregnant and then became a 'normal' couple who might choose to have obstetric care elsewhere, so she saw them only once. She had on-going contact with recipients if they had particular problems and sought support during their treatment process. This highlights the way the counsellor is positioned to manage the stress and emotional implications of infertility and fertility treatment which generally are not considered appropriate to discuss with physicians (Cussins, 1998a:74). Daniels (1992:63) suggests that physicians have neither the time nor the expertise to address the psychosocial issues related to conceiving children by DI. Moreover, Daniels, Spittal and Duff (1995) argue that some male doctors, and particularly psychiatrists and obstetricians and gynaecologists, are 'at risk' of becoming inappropriately sexually involved with female patients. As a result, they advise doctors not to offer "caring and support" to emotionally distressed (female) patients, and that counselling needs should be met by those specifically trained in counselling (Daniels, Spittal and Duff, 1995:289).

At the initial interview with the clinical specialist, a number of issues related to having a child by DI are discussed. Dr A said:

Dr A: I talk about our donors and what the donors go through. Well, it's important they know the process of why we do things and also that they're aware of the risks and the potential benefits of the way we go about things. And I talk about the law and how I see that and in terms of marital breakup. I will obviously talk about that if they're that individual couple's indications. That's why, if they're not clear cut I would have seen them beforehand. And then I tend to talk about success rates, what I would expect.

That Dr A discussed with couples the legal implications of conceiving a child through DI, especially if marital separation was indicated for the couple, raises the question of how this might be ascertained. The question also arises as to whether, and in what

circumstances, the policy that recipient couples should be in a 'stable relationship', as discussed in Chapter Six, is invoked. Furthermore, it points to the doctor as moral arbiter. Stephenson and Wagner (1991:46) claim that medicine is able to serve as moral gatekeeper because it has the capacity "to define abnormal and normal physiological functioning, appropriate sexual behaviour, and causal relationships between social factors (e.g. behaviour, morality, emotions) and disease states". Dr A also discussed with couples the likelihood of their achieving 'success' through the DI programme which, according to Cussins (1998a:75), "is wholly dependent on the establishment of in utero pregnancies, and the reinstatement of a 'normal' pregnancy trajectory".

A discussion of success rates in relation to infertility treatment can appear quite ambiguous and hypothetical in the context of each person's individual experience of treatment. This is because, as in the case of non-assisted conception, the likelihood of conception occurring varies from person to person and from cycle to cycle depending on a variety of 'variables'. As discussed in Chapter Five, the element of chance also inevitably plays a pivotal role in 'successful' outcomes. Nonetheless, understandably, recipients want to know their likelihood of success before embarking on treatment, but there are no guarantees that couples will conform to the statistical norm. While the probability of achieving a pregnancy on any given cycle may be low, (and this remains true for each given cycle), the fact that, in statistical terms, one in three or one in five cycles is successful justifies three or five attempts for recipients and physicians alike (Cussins, 1998a:76). Thus, projections based on statistics "licence doing the same thing again in the face of failure" (Cussins, 1998a:76).

Literature on success rates provided by one of the DI programmes indicated that couples could expect "at least a 15% live birth rate for each cycle of treatment" (see information provided by one clinic in Appendix C). In the same document, a table showing average success rates by treatment states: "We expect approximately 30% of women to conceive by the end of the 3rd treatment. In our programme from 1984 to 1992, 63% of women had conceived by 12 cycles". From these statistics, it is difficult for individuals to determine how long it might take them to get pregnant. Two nurses working for one DI programme said that recipients were generally told that there was a 15% chance of success each cycle. According to one of the nurses,

recently the clinical director had tried to temper recipients' "unrealistically high" expectations, which almost inevitably led to disappointment, by telling couples that they had an 85% chance of *not* getting pregnant each cycle. When I asked Dr A if, in fact, the chance of success per DI cycle was about 15%, he said:

Dr A: Yeah, yeah. It depends. I tend to look at our figures related to what the diagnosis is. Now, if the man is mildly oligospermic then our success rate for donor insemination is probably only 60-65% overall. And of course an age factor comes into that as well. If the man is not producing any sperm at all, so he's azoospermic or severely oligospermic, then the chances of that couple having a baby are probably about 80%, because, what it really means is, if the man has some sperm, or a reasonable number, then it probably means that the woman, if she was really fertile she would have got pregnant anyway, so she's therefore of lower fertility. If the woman's not getting any sperm, not being challenged by sperm, is the way I tend to put it and the couples seem to like that idea (he laughs), then more likely the success rate is higher. So I go through those issues. I go through issues related to the cycle and things like that.

KH: And would that success rate be over about five or six attempts?

Dr A: Yeah. Well, most of the pregnancies occur within about six months if they're going to occur, although we do have pregnancies up to two years...well, you know, sort of 18 or 20 cycles.

Dr A said that he did not place a limit on the number of attempts a recipient might have because this added to an already stressful situation. Nevertheless, this raises the question of whether it benefits all couples to keep relentlessly trying to conceive. In her research on infertile people undergoing fertility treatment, Becker (1994:390) found that a long drawn-out treatment process sometimes added to respondents' sense of disruption and undermined their sense of life as a continuous whole.

Usually, if the male partner was azoospermic, Dr A would assume that the woman had 'normal' fertility, and she would have three unsuccessful intracervical inseminations (ICI) before he would investigate her fertility.<sup>7</sup> At this time, he would also look at changing the treatment regime from ICI to interuterine insemination (IUI), to improve the likelihood of success. This strategy illustrates the way that clinics manage lack of success: procedures and protocols are fine-tuned with each cycle to reinstate the idea that there was a specific reason why the previous cycle did not work, and that this can be taken care of in the next cycle (Cussins, 1998a:76).

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<sup>7</sup> This avoids potentially unnecessary and more expensive and physically invasive interventions for women. The reasons for this clinical protocol are discussed in more detail later in this chapter.

Lack of success for some recipients was a source of stress, not only for the couples themselves, but for the health professionals who ‘treat’ them. A nurse said about her job:

Nurse B: It is [satisfying]. It is very frustrating in other ways. And it can be hurtful. But you feel... I feel deeply for people who keep coming back and back and back and things don't seem to happen. And I know there's nothing much I can do about it. ...whatever it is that motivates them, that they're not able to sort of call a halt...quite often we'll encourage them to have a break for a few months or something like that, if you feel that they're getting really stressed. You'd think that each cycle that was unsuccessful, you'd think things get easier, well it doesn't, it gets worse, because each time they sort of look at those figures we give them... the wretched statistics, they're terrible things really, but that's all you can give them. They often feel that it's very unfair that they haven't got pregnant yet, and more often than not we will refer them to the counsellor and if they don't contact her, we will sometimes ask her to contact them. We try and meet with [the counsellor], oh, about once a month or something, and discuss any problems that we've got and tell her about pregnancies that have been achieved, or babies that have been born, and those sort of things. It is. It's a very rewarding job.

Nurse B attributed couples' determination to continue treatment to their own agency, rather than to clinical practices. Certainly, the desire to continue treatment and achieve a pregnancy may relate to couple's efforts to re-establish a sense of continuity in the face of the disruption of infertility (Becker, 1994:390). Cussins argues, however, that clinical practices that construct the treatment process as open-ended and define ‘success’ in terms of the normal functioning of the woman as pregnant, also entice women to keep trying to conceive (Cussins, 1998a:75). Herein lies the disciplinary power of the fertility clinic: it operates not through coercion but through its emphasis on normalisation: “by inciting desire, attaching individuals to specific identities, and addressing real needs” (Sawicki, 1991:85). This explains its powerful allure and why couples find it difficult to ‘give up’ before having succeeded in conceiving and giving birth.<sup>8</sup>

Nurse B, who shared the job of DI programme nurse, said she attended the initial consultation between the clinical director and the recipients.

Nurse B: ...because of the days of the week I've been working, I have been the nurse who's sat in on the interviews with the new couples who come through, and that has been a very interesting and steep learning curve. I mean, I might have only been shown how to do an insemination.

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<sup>8</sup> When carrying out her research in an infertility clinic, Cussins saw only one person give up treatment without a recommendation from the physician, without severe financial pressure, or without being pregnant (1998a:76). The woman, she discovered, had an alternative interpretation of her infertility based on her religious beliefs which was at least as powerful as that offered by the medical model.



I knew very little about infertility before that, except you pick it up as you work around the place, over the morning tea table more often than not. But it was something that every time Dr A interviewed a couple I learned a whole heap more, and so it was good... about infertility and, well, really about male infertility which is what the main emphasis was, of course, in his interviews with first-time-through couples.

While Nurse B had no prior knowledge of infertility, Nurse A had children conceived by DI, and wanted to work in this field as a way of “giving something back”. She said:

Nurse A: I think my own experience has been helpful in working in the programme. I've had a lot of changes and the decisions with that, and things are certainly vastly different now from what they were when we were going through the programme.

Peter and Alice, a recipient couple who had conceived through this DI programme, appreciated interaction with a nurse who had used DI. Peter said:

Peter: Actually, the nurse that helped us the first time has her own donor children, so that was actually quite a good... quite a helpful thing to know. So... there was a bit of empathy at least... you knew that the person who was helping you was probably the best person you could have helping you.

Peter's comments illustrate the care given by nurses on social and psychological dimensions, in addition to their expertise in monitoring biological processes related to the menstrual cycle. Nurse A explained the role of the nurse in terms of the practical/biological/technical aspects of preparing recipients for the inseminations.

Nurse A: [After the initial interview] the role is then to teach [recipient women] how to test their urine at home, so they can learn to track their cycle. So, education's a big part of it. A lot of women haven't been aware of their fertility until they start the programme. So, we teach how to understand their mucus, so when they're about to surge we send them off for blood tests, to make sure they're immune to rubella, this sort of thing. And we tell them they're to phone us on Day 1 of their period, and we will then tell them when to start testing their urine. We show them what the insemination is like, we explain to them what the process will be as far as the insemination is concerned.

Nurse A's explanation of the nurse's role of educating recipients highlighted that it is women's bodies that are being disciplined and subjected to surveillance throughout the clinical process. As Cussins argues, treatment has a number of paradoxical effects: “couple” becomes almost exclusively the female partner, and “natural cycles” give way to disciplined cycles, regardless of the infertility diagnosis (1998a:75).

### The role of counselling

This section is not intended as a comprehensive overview or analysis of the role of counselling in fertility clinics. Rather, it highlights and discusses some of the ambiguities, contradictions and controversies that exist in relation to this particular service. In New Zealand fertility clinics, while one counselling session is generally required in connection with most fertility treatments, the role of counselling is controversial. The term ‘counselling’ in the context of DI appears to refer to at least three separate activities: information giving and discussion, support and therapy, and selection or screening (Daniels, 1993). Whether or not all these functions should be part of the counselling role, however, is debated (Daniels, 1993). On the basis of their research, two Australian psychologists, Walker and Broderick (1999), claimed a discrepancy existed between what donors and recipients were saying and psychological ideology and practice in the area. As a result, the authors questioned the need for what they called a “therapeutic injunction” in fertility clinics.<sup>9</sup> The article, nonetheless, prompted a number of responses from social workers and counsellors working in the field that disputed these claims.<sup>10</sup>

The president of the Australian and New Zealand Infertility Counsellors Association (ANZICA) has argued that the primary function of counsellors in fertility treatment programmes is to explore with donors and recipients “the psychological, emotional, social, and legal implications of the medical interventions they are considering undertaking” (Blood, 1999:216). Other social workers have referred to the role of the counsellor in addressing issues such as the “emotional impact” of infertility and the psychosocial issues<sup>11</sup> related to conceiving with donated gametes (Daniels, 1992; Daniels, 1993; Daniels and Stjerna, 1993; Mahlstedt and Greenfeld, 1989). These

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<sup>9</sup> Walker and Broderick (1999a:221) suggested that the “therapeutic injunction” rests on three claims that are not supported by empirical evidence. First, that it was wrong not to tell children of the method of conception and that doing so constituted “keeping secrets” that can lead to genealogical bewilderment; second, that the model of “open adoption” should be applied to donors, recipients and children; and third, that the argument for a therapeutic injunction relies on evidence from research on psychosocial issues in assisted human reproduction that are limited and cannot be used with certainty to support policy, legislation and practice.

<sup>10</sup> For this debate, see Walker and Broderick (1999a) and articles written in response to this controversial article, published in the November issue of *Australian Psychologist*, including Rose (1999), Walker and Broderick (1999b), Lorbach and Lorbach (1999), Blood (1999), and Daniels (1999c).

<sup>11</sup> Daniels (1992:57) defines the term psychosocial as representing a combination of the words psychology and social. The psychological dimension of the word refers to an emphasis on individual,

issues include secrecy and information-sharing, donor anonymity, the meanings attached to biological and social parenthood, social attitudes towards the use of donor gametes, the implications for the relationships of the parties involved this form of procreation, and issues related to the welfare of the child (Mahlstedt and Greenfeld, 1989; Daniels, 1996).

As stipulated by RTAC, the fertility clinic accreditation body for Australia and New Zealand, DI programme recipients must receive adequate information as part of the process of giving informed consent prior to treatment. As previously discussed, the counselling session is generally constructed as an opportunity to prepare clients for what is involved in the treatment programme and therefore is an 'information giving' session, rather than one of assessment.<sup>12</sup> As well as providing information about the treatment programme, counsellors interviewed for this research addressed the psychosocial issues relating to infertility and fertility treatment involving the use of donated gametes. The counsellor working in one of the DI programmes had worked in the field of infertility counselling for ten years. Part of her work involved interviewing recipients on the DI programme. She said she usually began the session by talking about infertility and the implications for the couple's relationship. She said:

Counsellor A: I usually start off by asking them how long they've been together. When did they start trying for a family? And, how soon did they go seek treatment? How soon did they feel that things weren't going right? So, I sort of take them back to when they first got together, and just work from there forwards to get some idea of where they went to first...it's usually a GP...what happened there, then what happened, and then when there's a diagnosis comes in, then we find out that he had...and then I ask them, and how was that? You know, how long ago was it...got an idea because we're working backwards, forwards and, how was that for you two? So, we do talk about the infertility. It's not a whole session on it because they've got one session before this DI. The session lasts about an hour and a quarter, maybe an hour and a half. Not much, not...and I mean there are other programmes that have two sessions, which would be really good. So, I give them handouts. If it seems appropriate, if it brings up things for them, if it's still very painful for the man, I make sure that I give them some reading around that, because very often, they're quite isolated in their coming to terms with that, apart from their partner, and, isolated in as much as gender-isolated.

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internal or intrapsychic factors, while the social dimension emphasises relationships, the interpersonal and interaction.

<sup>12</sup> See Appendix C for a copy of one clinic's brochure outlining the role of counselling. Contrary to what is indicated on the brochure, and as noted in Chapter Six, counselling also includes an assessment function.

The narrative approach taken by the Counsellor A appeared to be used as a tool to elicit information, in a non-threatening way, about people's reactions to infertility, how it affected their relationships, and the critical moments that led to their decision to consider conceiving with the use of DI. Counsellor A indicated that one session of about one and a half hours was barely adequate to cover this.

A nurse working in the same DI programme said that in the past many recipients were resistant to having to see a counsellor as part of the treatment process.

Nurse A: Some people have been resentful in the past "oh why do I need to see a counsellor?" But we include this as part of our programme, and they are told it's not a screening process, but she's there for information giving, and I think barriers have been broken down with couples resisting seeing a counsellor. And most of them say it's been very valid, and they know then that she is a point of contact if they wish to have contact with her in the future. If they're feeling stressed with the programme, and they don't want to discuss it with us, which is fair enough, at least they have her that they can go to.

Nurse A's comments about the validity of counselling illustrates Cussins' argument, raised earlier in this chapter, that in the context of fertility clinics it was not considered appropriate to discuss emotional issues or "psychological factors" with physicians, and that this should be confined to interchanges with nurses or counsellors, or the privacy of one's home (1998a:74).

Resistance to seeing a counsellor in relation to fertility treatment might also partly be explained by a general perception that the decision to have children is a private matter that should not have to be justified to anyone. Illustrating this point, a recipient said that when the clinic nurse had asked her at an initial interview why she wanted children, she had said that she did not know, and questioned whether anyone in fact knows why they wanted children. This suggests that the "decision" to have children is not a matter of rational choice. Birke, Himmelweit and Vines support this view, arguing that many political ideologies conceptualise reproduction as "a private concern of individuals and their families: more a matter of feeling than thinking, in which the state has no right to interfere" (1990:30). In her research into what motivates New Zealanders to have children, Cameron (1990:55) found that many respondents offered biological explanations for wanting children, including that it was "just natural" or instinctive.

Counsellor B said she had encountered resistance to counselling from some recipients:

Counsellor B: I try very much not to be in a gatekeeping role. There are some people who immediately feel very defensive about having to see a counsellor, and some people are actually quite negative, but that would definitely be the minority. But there have been a few situations where that has been some difficulty. I think that some people felt that they were being evaluated, and on a particular level I guess I am evaluating them, to make sure there is nothing in terms of their functioning or history which might mean that DI is really not appropriate for them.... So that has been quite difficult, and I always make it clear that's not what I see my role as being, but that I'm interested in hearing about any serious concerns that they might have about going ahead with it and that they could discuss those with me. So, at its most basic level, it's sort of information giving, clarifying how they got to this point.

The role of counselling appeared not to be deeply entrenched in the 'culture' of this particular DI programme.<sup>13</sup> The director of the DI programme commented:

Dr C: Most recipients discuss with me donor insemination as an option, and may not decide on donor insemination, but I would still give them an assessment of their suitability: one is that they understand the issues, the psychosocial issues that are involved. From there they would... we do have a policy here for all recipients and donors of gametes that they have counselling. We do try very hard for couples to have counselling. I mean, there are exceptions, I mean just a year or two ago we had a couple who were both social workers, for example, who we didn't sort of counsel at the time. Some couples are extremely widely read about the whole programme. They understand the issues very much; others don't, and it is through the counselling process, and also they have an interview assessment with [the nurse] as well, whose responsibility it is to discuss and give them the donor profiles and that sort of information that they need. But I think that the process is pretty straightforward. We do have a clinical guideline. It's a protocol for couples in the assessment and participation in the programme to ensure that we don't overlook some issues. For example, after three failed cycles the guideline says that they should be reassessed by a clinician.<sup>14</sup>

Dr C maintained that the clinic had a particular protocol – a form that ensured that all recipients were given adequate care and assessment throughout their treatment process.<sup>15</sup> Nonetheless, couples did not necessarily attend a counselling session.

Several recipient couples interviewed for this research reported not having had a session with a counsellor before embarking on DI treatment. This was particularly the case for couples who had been through the programme in the late 1980s or early 1990s. Mary and Brendan, the parents of two children conceived by DI, aged 12 and

<sup>13</sup> At the time of the interview, Counsellor B had been working at this clinic for only 10 months. In the past, counselling appeared not to have been offered consistently to DI recipients.

<sup>14</sup> While this protocol is now in place, a recipient I interviewed had nine unsuccessful cycles of DI treatment before her fertility was investigated. At that time, a laparoscopy revealed that she had blocked fallopian tubes which were remedied with laser treatment. She subsequently conceived on the next DI cycle which raises the question of why her fertility was not investigated earlier.

<sup>15</sup> A copy of this clinical pathways form which is designed to assist clinicians in measuring and improving clinical outcomes appears in Appendix C.

10 years, said they were initially given very little information on the social issues in connection with DI. They said:

Brendan: [Clinical staff] were really just testing to see whether we were satisfied ourselves that we wanted to go on the programme. It mainly hinged around that. They didn't really talk about how we would feel about having the children or anything like that. It wasn't even raised that I can remember.

Mary: No, I think the only person that came around and said that was [a social worker carrying out research in this area]. He was the only one that came and talked to us about sort of feelings about the children. The doctors didn't say anything about that at all. Although at some stage we must have talked about that. I think in the letters, the letters we got from the fertility [clinic] after we'd had the children, mentioned that most people were telling their children, and if we felt that we needed to talk to them about it we could contact them.

Some couples receiving DI treatment through this clinic were aware of the clinic's policy of 'openness' in relation to telling the child of his/her origins, and had wondered if a willingness to tell the child was critical to their being accepted for DI treatment. The father of triplets conceived by DI said:

Allan: Well, they did an assessment before they would accept us though. We had to go for an interview with [the nurse] for half an hour or an hour. She filled out a questionnaire and asked various questions. And I remember thinking, you know, being honest with my attitude, this is obviously going to be going against us. But obviously it didn't kill the idea.

Allan said that he and his wife had been 'assessed' by a nurse, rather than a counsellor, in the DI programme. At that time, he found that his resistance to openness did not preclude them from being accepted for DI. Other recipients were mindful of the clinic's message that it was desirable to tell the child, but maintained that it was not delivered directly or coercively. Paul said:

Paul: I think it was pretty much left up to us, though I think the underlying current of conversation was towards openness, but there was no... you didn't feel any pressure, or...and it wasn't talked about in a direct sense in the way that I sort of received it but I just sort of felt that the way that they talked to me or us was really in a pretty open sort of a way and that's the sort of underlying feeling I got... and I think we did ask about it... I think that the nurse said that when she raised it that it seemed to be more of a concern for the parent than it ever was for the child, you know, breaking the news to the child seemed to be "so what?" sort of thing, whereas the parent seemed to be going through all these agonies of, you know, "How am I going to respond and all this?" sort of thing.

Many couples indicated that the clinic had provided useful information on aspects of negotiating relationships after having a child by DI and, in particular, about telling the child of his/her genetic origins. But not all couples felt that they were prepared for the emotional and social consequences of having children by DI. Andrew and Annie,

who had not initially seen a counsellor when they went through a DI programme, said:

Annie: We actually were not given any counselling, and I think it should have been there right from the start, because it was only later when we fell into trouble going through for our second child, that this was sort of brought up, and the fact that Andrew wasn't talking about it. Then we went to see a counsellor. It wasn't until that time. I think we *needed* to and that was part of our problem, for Andrew anyway...

Andrew: It's a lot to do with the emotional state. So, if you're going on the programme, you need to be quite relaxed about the whole thing, and what we didn't have was information about the after-effects, the lead on, and what happens after birth, one, two three, six years of age of the child. No knowledge of that at all. No information about it either. It's all about the mechanics of the process, how you're meant to feel, but you don't feel like they say. Life's never like that in the real world.

As discussed in Chapter Eight, Andrew and Annie were secretive about their fertility treatment, so were isolated with no support network. Andrew, in particular, was extremely stressed by his infertility, but for a long time had resisted seeing a counsellor to discuss his reactions to his infertility, and the DI conception of his daughters. Andrew's resistance to counselling was not atypical of men, according to the counsellor at one of the fertility clinics.

Counsellor A: [Men] all would find it difficult to come along, but they all say that it was okay, yeah. And it is okay. And I'm a story-teller, too, so, I tell them about other men's experiences. "I met a couple who..." and "There was this builder who..." you know, "and he found that he told them on site because he was so devastated it just came out, and one of his mates said, "Well, why do you think we've adopted two?" You know, and it was a general topic of conversation. So, yeah, I sort of normalise in that way by being anecdotal myself. It's quite liberating sometimes. But I also respect privacy, because some people... it's a very intimate subject and some people find it hard to connect with other people on any level, let alone that deep level.

Story-telling was a useful resource for addressing a delicate issue with men who were, at least at first, resistant to seeing a counsellor, let alone discussing their 'feelings' about their infertility. These accounts reveal that men are 'treated' too on the DI programme, but by counsellors rather than medics, albeit usually in only one brief session. The scientist working for the same DI programme indicated that many infertile men entering a DI programme with their partners possibly felt distressed, isolated and marginalised, not only because of their infertility, but because women tend to be the focus of treatment. She said:

Scientist: I'm sure for a lot of these fathers it must be quite difficult. I doubt that they easily get over the problem that they are infertile, and that there's something lacking in them that they weren't able to father a child. And even having a child doesn't actually cure that infertility problem. They may have a child but they're still infertile. And I sort of wonder if perhaps

there aren't still quite a lot of [social] fathers who don't still have, you might say hang-ups, unhappinesses, you know, unresolved problems over this issue which no-one does anything to address at any stage, I don't think. They tend to be not the focus of the treatment. It's mainly the woman who gets most of the attention and time, and I guess they get a joint counselling session with the counsellor but one session probably doesn't get you tremendously far in this.

The scientist was aware of the possible emotional difficulties encountered by infertile men, like Andrew, and the short-comings of a clinical system which is primarily concerned with 'treating' women so they can become pregnant.<sup>16</sup> She also supported the counsellor's contention that one session to discuss the complex emotional, social and psychological issues around infertility was somewhat inadequate. Meerabeau (1991) hypothesises that men are marginalised in fertility treatment programmes because doctors, who are usually male, identify with the men whom they anticipate would be embarrassed to discuss their infertility, and because men play such a small role in reproduction and subfertility investigations generally.

Like Andrew and Annie, Jennifer and Petra, a lesbian couple who conceived through a DI programme, commented that the primary focus of the DI programme was the mechanics of achieving a pregnancy, rather than the social issues pertinent to families with children conceived by DI. They said:

Jennifer: I got the feeling from Dr A that he was more interested in the clinical side than the social side. He sort of left it up to the social worker to do her bit, and when we got through that part he just explained to us the way it worked and the process, and more the mechanics of it, rather than the social aspects.

Petra: Yeah, it strikes me that he's a bit like a kid with toys isn't he? He likes to make it work, and he's not really concerned about the people attached, so he prefers the people to be quite laid back. I got the impression he would be quite scared if we were more abrasive or more sensitive than that. But I think he was...my impression was that since we were quite laid back, he was calmer and, like, the forms...they haven't degenderised the forms, so they're still quite heterosexist. But he made light of that and when we were happy to make light of that as well, I think he was relieved probably. I think he thinks it's a bit weird, but he doesn't make any value judgement about it. Do you think that's fair?

Jennifer: Yes. He's a doctor at the end of the day. He's interested in the science of it rather than the social issues.

Petra: Yeah, and he likes to get people pregnant, basically, you know, and that's brilliant.

Petra raised the important factor of patient comportment in the clinic. Cussins (1998a:73) observed that all "patients" needed to behave appropriately in the clinical

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<sup>16</sup> The on-going emotional issues experienced by some men in relation to infertility and DI treatment were discussed in more detail in Chapter Four.



setting or they risked forfeiting their status as patients. Cussins suggests that appropriate comportment both guarantees a patient's fitness to receive treatment and provides the physician with a moral justification for offering his services (1998a:75). Jennifer and Petra were aware that the clinic was not particularly 'geared' to catering for lesbian couples, but refrained from commenting about it in the clinical context. They said:

Jennifer: As far as lesbian couples going through the clinic go... I don't know when the first lesbian couples went through the clinic, but I suspect it was quite recently, but I don't think they've been thinking through what the implications are and how it's actually different. It does feel like... even the conversation we had about Petra using the same donor and stuff, they hadn't thought it through, they hadn't been presented with it before.<sup>17</sup>

Petra: But then they never assumed that we would want more than one child.

Jennifer: Well, they assumed right from the very first interview that we *wouldn't*. I remember Dr A saying, "Oh, now you're wanting this baby," and I said, "We don't see it as having a baby, it's just we're starting a family, and we'd like four," and he just kind of giggled, and said, "Oh, we'll just work on one at a time," and didn't want to discuss it.

Dr A's reaction is consistent with a focus on the biological rather than the social family, but also indicates his qualms about treating those who do not conform to the heterosexual nuclear family model. It thus brings into sharp relief that reproductive technologies such as DI enhance prospects for 'alternative' as well as traditional families, and therefore potentially weaken the hold of the nuclear family as a societal norm (Wasserman and Wachbroit, 1992).

As possible further evidence of the clinic's reluctance to assist lesbian women to conceive, Jennifer and Petra found that the student social worker they saw in the usual counsellor's absence was unprepared for the appointment with them. They said:

Petra: The Social Work student started by saying, "I've never actually met any lesbians before...worked with any lesbians before, so tell me if I'm doing it wrong."

Jennifer: It wasn't a good start really.

Petra: Well, it was just like, "okay".

Jennifer: But it was very evident that she actually hadn't thought through the issues that were involved for lesbian couples.

Petra: She showed us a book which was how you explain to your child that one of you is not the father, you know, and I mean it was just bizarre, and then she said, "Oh, I guess this book isn't

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<sup>17</sup> See Chapter Six for discussion of the tension between the clinical definition of a family and Jennifer and Petra's conceptualisation of themselves as one family.

very appropriate for you is it?" I mean, good book in that circumstance, but you'd think you could screen it out when you know you're seeing two women.

Jennifer: Or you could say, "You might find some of this book useful." I just had to wonder what kind of supervision she has as a Social Work student, knowing that she was coming to see a lesbian couple, because a lot of information that she also gave us was wrong...she said that all of the men on the programme were willing to have lesbian [recipients], which is not true. So she had to ring and apologise the next day and give us the more correct information.

Petra and Jennifer had gone to the session with a prepared list of questions that they thought would be raised for discussion. When this did not transpire, they raised the questions and supplied their prepared answers for the student social worker. In this situation, they were positioned as the 'educators' in the encounter with the social worker, rather than the other way round. Later in their treatment process, the couple had a more helpful and supportive encounter with the clinic's regular counsellor.

### **Insemination and conception**

Recipients' experiences of the actual insemination process varied. For some it was emotionally traumatic. This was related to a number of factors, including the failure to get pregnant and the need for on-going inseminations, and the meaning attached to being inseminated with the semen of an unknown man. Andrew and Annie said:

Andrew: I mean, sure, you went along there and got inseminated. That's probably easy, but Annie had immense problems with having someone else's semen inside her.

Annie: Actually I cried most of the time when we went up there, didn't I? (she laughs)...It was quite awful.

Andrew: And then, as a husband, the fertility people said it was the idea to go home and make mad passionate love when you got home to make it feel all better, and from my perspective that was very, very difficult.

Annie: They suggested that the first time, but the second time around that it wasn't even mentioned.

The suggestion that Andrew and Annie go home and make love was a practice employed at a time when clinics advocated secrecy and thought it easier for couples to accept the child, if they imagined it was in fact their 'own'. Andrew had difficulty relating to his wife after the inseminations. He said of the emotional issues for him:

Andrew: Is it a sense of rape? Is it a sense of deceiving someone? Is it a sense of having an affair? All these sorts of things. All these emotional things are on top of the process of going on the programme. There's all these issues that follow on that one doesn't think about and it means coming to terms with that. Annie found it very difficult because I wouldn't talk about it.

Annie: At that time, and I think it was the hardest time of the whole thing for me personally, it would have been nice to have talked to somebody who had been through it, not a medical

person, or a family friend even, I mean somebody who had actually been through it. That would have been actually quite good.

Annie and Andrew attributed the length of time it took for Annie to conceive their second child (18 inseminations) to the stress they encountered throughout the treatment process. The issues raised by Andrew and Annie might have been usefully explored in counselling sessions. As discussed in Chapter Four, Andrew had not had time to come to terms with his infertility before beginning DI treatment, and this probably accounts for how he felt.

Like Annie, Jane found the insemination process difficult to contend with emotionally, though her husband Steve's response was different. They said:

Jane: ...the donor thing from the beginning sort of did create a sort of...the insemination...that created a bit of a block. It did to our relationship, I'm sure it did. Just going through it...just because it wasn't the norm...

Steve: No.

Jane: It wasn't for you, but it was for me, because the whole thing is sort of cold. You go up there, and you have this insemination.

Steve: I think from her...from the woman's point of view...different...different.

Jane: Yeah, really emotional. I found that really hard to grasp with, and, it was sort of cold you know. Even though they try to get you to, you know, to keep on with your relationship with your husband afterwards, but I found that really hard.

Jane and Steve appeared to have been given the same message by clinic staff as Andrew and Annie: to "go home and make love". To Jane, conceiving in the clinical context was "cold" in contrast to conceiving through sexual relations in the privacy of one's own home, and in the context of a relationship but, having been inseminated, she found it difficult to resume 'normal' sexual relations with her husband. In contrast, Steve was more concerned that his failed vasectomy reversal would 'unblock' which could potentially disrupt the planned DI conception by making it difficult to determine whether he or the donor was the genetic father of the child. He attributed Jane's feelings to how women, generally, would feel in the same situation.

Not all women recipients felt like Annie or Jane. Some took a more pragmatic view, experiencing the inseminations as a means to an end. Sarah said:

Sarah: Tim was there at the inseminations - him and Rob [their oldest child] came up and were sitting next to me. He probably didn't want to do that, but I made him get involved because I wanted him to be involved in the whole process, and for him to realise that it was no big deal for me. I mean DI's quite amazing, and it's probably actually the simplest procedure to get a family, if the woman's fully functioning, but it's probably the hardest morally to get your head around. Like, even with egg donor, women and husbands will accept having another woman's egg far easier than the whole idea of having another man's sperm. And that just never concerned me, I just thought, OK, it was just a quick smear, in and out job, no worries. A bit of discomfort, but I expected that. But for other women that I've talked to, it's been like the most horrendous thing they've ever done.

Sarah had been sexually abused as a child, and had sought counselling in relation to their infertility, so it is possible she worked out how she was going to handle the inseminations. She raised the issue of the difficulty couples have with using donor sperm because of the sexual connotations involved, issues which do not seem to exist where egg donation is concerned.<sup>18</sup>

Although Sarah said that Tim perhaps would have preferred not to attend the inseminations, several men said that they welcomed their involvement in the insemination process. Neil said:

Neil: It was important to me to be involved, to go along to inseminations, even if it was just warming up the straw. We got the straw, and warmed it up (he laughs) [Neil shows how he rubbed the straw between his hands to thaw the frozen sperm]. ...although the one that worked I didn't warm the straw up. The nurse did that. I really wanted to warm that straw up. But still, it was successful.

Like Sarah and Tim, Neil and Patricia took their first child, aged nearly four years, with them to the inseminations when their second daughter was conceived. Patricia said:

Patricia: Well, she knew beforehand that story about a kind man giving us sperm so that we could have her, and we didn't sort of dwell on it, we were just going in to get some more sperm.

Neil and Patricia regarded the experience of taking Tracey along to the inseminations as part of the process of allowing her to understand how they 'created' their family.<sup>19</sup>

Whereas Neil was able to participate in the conception of his daughters by warming the straws, some men were also able to perform the inseminations. Richard and Belinda said:

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<sup>18</sup> The issue of the different meanings attached to sperm and egg donation was discussed in Chapter s Four and Ten.

<sup>19</sup> For a discussion of the different 'scripts' for telling children of their DI origins and the alternative framings of these conception stories, see Chapter Nine.

Richard: During the insemination (pause) I was able to do it, to inseminate Belinda, more so than just go in there and the nurse do it. So we could basically do it all ourselves...

Belinda: So we were able to joke with some of our very close, dear friends and say, "Well, Richard did the deed, as such." And that, to us, was really special that Richard actually did do it. Because as some of our friends who do IVF say, "Well, you know, it's all in the test-tube. It's all up to the doctors," where it was us that did it.

Richard and Belinda had a sense of taking control of the conception process themselves rather than it being entirely controlled by medical or technological intervention. This situation also illustrates the way that parenthood can be constructed through intentions and actions rather than through genetic substance. Although the inseminated semen was not his own, because of his intention to be a father, and through the physical act of inseminating Belinda, Richard was constructed as the 'real' father of their daughter Madison.

Female lesbian partners were similarly able to derive pleasure from being involved in their child's conception. Petra recalled her involvement in the insemination process:

Petra: In fact, the last insemination was an intrauterine insemination, so I didn't do it.

Jennifer: But you'd done all the other ones.

Petra: Yeah. Yeah. I did the ones that didn't work (they laugh). I always worried about that (she laughs).

Jennifer: They say that after the first three times if you haven't conceived they usually try IUI. And they'd done a hysterosalpingogram, you know, where they put dye through your tubes. They'd done that, and they'd done a scan and everything was all right. So they just...

Petra: It's just Dr A has these toys, he likes to up the stakes. He doesn't like to hang around, so...and that was fine.

Like Neil, who had wanted to warm the straw for the insemination that 'worked', Petra joked that she would have liked to have been able to say that she had performed the insemination that resulted in the conception of their daughter. Petra suggested that the doctors increased the odds of success by using more sophisticated 'toys for boys' which indicated a degree of ambivalence towards their use; at the same time, she conceded that the use of the technology produced the desired result, both for them and for the clinic. Dr A described his strategy to change to IUI after three unsuccessful attempts of ICI:

Dr A: We've always had a pretty high pregnancy rate in the first two or three cycles, although recently, and something probably related a bit to the group of people coming through, our first two or three cycles have been a little bit less successful and then we've got more pregnant with intrauterine insemination when we go onto that. Some programmes do IUI, intrauterine insemination for all of them. Fertility Associates<sup>20</sup> do it that way. But until recently, our success rate in the first two or three cycles was as high as theirs was anyway, and because it was therefore cheaper and less invasive and nurses could do it very easily, and they had more time, then that was why I've always done intracervical. Last year we got a slightly higher pregnancy rate with IUI than we did with intracervical and I'm sort of thinking, well, do we do anything about it? It may be a statistical quirk and we just have to see.

Dr A's comments illustrated the clinicians' focus on patients, more technically demanding types of treatment and treatment outcomes (Daniels, 1999a:9). According to Cussins (1998a:87), health professionals in fertility clinics are aware that the statistics alone predict that dry runs should occur but, in the short term, they cannot be sure whether local lapses are just dry runs or if they indicate that changes to procedures are having detrimental effects. As a result, they have to respond to local failures to maintain success rates before they have the data to make this judgement. Dr A's acknowledgement of the need to monitor success rates by making comparisons with the success rates of other clinics in the country highlights a degree of competitiveness between the clinics based on treatment outcomes and numbers of pregnancies.

In contrast with the experience of conceiving in the clinical setting, Sophie and Ria were a lesbian couple who used self-insemination procedures to conceive their daughter. Wikler and Wikler (1991) have argued that the practice of self-insemination raises two important challenges to the medicalisation of DI. First, they argue, its success raises the question of the need for a doctor's technical skills, and second, the fact that it can be used by single women questions its use as a 'therapy' for couples suffering from male infertility (Wikler and Wikler, 1991:6).

Certainly, Sophie and Ria chose this method of conception rather than a 'clinical' conception but, as a result, they had to do certain 'work' themselves, such as finding a donor and learning how to do the inseminations which those who go through a DI programme pay a clinic to do. By organising and carrying out the inseminations themselves, their experience was 'different' but not necessarily 'better' than if they

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<sup>20</sup> Fertility Associates is a privately-owned company that operates three fertility clinics in the North Island of New Zealand.

had been through a clinic. They had learned the practicalities and technical aspects of doing the inseminations from a book entitled *Challenging Conceptions* (Saffron, 1994). They had learned how to store sperm, what to look for in healthy sperm, how to transport it, how to calculate their fertile days, when to inseminate, how often to inseminate, and so on. The book suggested that they inseminate several times: every second day around the time of ovulation. They recalled their insemination experiences:

Ria: And so we gave Derek [their 'donor'] dates.

Sophie: And he came around with a jar wrapped in his undies.

Ria: The first time he came around we were all just so uncomfortable and embarrassed about the whole situation.

Sophie: We didn't know what to say, or didn't know whether to say, "sit down and have a drink." We didn't know what was going to happen there either; whether he was just going to go into another room and do it, but neither parties would have felt that comfortable with that anyway. And they say it's best to leave it for twenty minutes after he's ejaculated anyway because it liquefies again. It sort of goes out of its jelly state. So, it's easier to take up with the syringe and inseminate. We have been really lucky to have really supportive medical people around. Our doctor, we got through Derek, is also a gay man, and he's been excited for us, and really helpful. He put us onto the Ettie Rout Centre<sup>21</sup> and we got a speculum from there, so we were able to see where the cervix was and see where we were aiming for, which was good too.

Ria, Sophie and Derek had obviously not discussed the finer points of how the transaction would take place. In contrast, in fertility clinics, because the circumstances for the blurring between private and public are so pervasive, they have a "well worked-out choreography of privacy" (Cussins, 1998a:89). In these settings, the transition between private and public is smoothed over by protocols whereby men hand over a sterile container of semen directly to someone who will deal with it technically. Although they used a 'do-it-yourself' technique for conceiving, Sophie and Ria welcomed support from medical professionals, who gave them information and access to the use of a speculum. They also relied on the results of Derek's regular medical tests to confirm that he was not infected with HIV before they began the inseminations.

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<sup>21</sup> The Ettie Rout Centre provides support, counselling, medical testing and educational services for people who have HIV, and men who have sex with men.

Sophie performed the inseminations. The book they consulted had recommended five inseminations per cycle.<sup>22</sup> They were convinced that Ria had conceived on the fourth insemination of the third cycle. They said:

Ria: We were using the same syringe and we were sterilising it each time, and on the month that I became pregnant, the fourth insemination we did, and then we were getting everything sterilised for the fifth insemination and the syringe broke right at that time, so we ended up using a teaspoon.

Sophie: No, I just tipped it in in the end because the teaspoon didn't fit in the speculum, and I thought oh no, what are we going to do?

Ria: So we're quite sure that we conceived...

Sophie: We just felt that the second to last time that we tried we both really felt that it happened.

Like other women recipients of donor sperm, Ria said she had found the experience of being inseminated quite unpleasant and stressful.

Ria: The first couple of times we were a bit tense. The first time was definitely the hardest, and the second time was a little bit tense, but then friends of ours who have a child said that it's quite vital that you are comfortable and relaxed during the whole process, otherwise it wouldn't work. And I guess the first time that we tried it, I was extremely grossed out by the whole feeling. The smell, and the actual sperm being in me. I was really uncomfortable about it, and I thought, if I can't get over this feeling, it's not going to happen.

Other women attributed their failure to conceive to stress factors. Joanna, the separated mother of two children conceived by DI, said:

Joanna: I had two inseminations, and then I lost that baby at three and a half months, and then I went on the programme a month after I lost that baby and fell pregnant with Todd. But with Jessie, well, she took about 12, 13 goes! And they actually put me on the list for the IVF, and I had surgery to see why I couldn't get pregnant and things, but they put it down to stress because Todd was in and out of hospital quite a lot as an infant. So they think it was stress, and probably why I couldn't get pregnant.

For some, the disappointment of not conceiving was difficult to contend with. Tania said:

Tania: Well, I had about four goes at it, and then they thought I had a miscarriage. So I had to have a rest. And it was really traumatic. Like the whole deal. We ended up in counselling because it wasn't working. And then at the beginning of last year I went back for one more go, and it didn't work, so they decided that they'd do IUI. So, and that just worked first pop. Just obviously wasn't getting up far enough (she laughs).

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<sup>22</sup> Recipients attending one of the fertility clinics also told stories of being inseminated several times over a few days during one DI cycle.



Tania's experience indicated that counselling services are recommended for those who are not coping with the stress of repeated failure to conceive. A nurse working in a DI programme said that she found it difficult to know how to help women to cope with the emotional stress many encountered in this situation. She said:

Nurse B: I was finding it really difficult, because I hadn't had any problems that way at all, ever (she laughs), and so I had no personal experience that I could share with them except the personal experiences that other people had expressed. And I've done a few psych papers, and um, I did Abnormal Psych a couple of years ago, and talked about some of the relaxation techniques and things, so I was busy trying to use some of this very slim knowledge to try and help people to try and develop some sort of tools to deal with this jolly stress that they have.

Nurse B claimed that many recipients' expectations were high when they went onto the programme, so the disappointment of 'failed' cycles was hard to bear. Not all recipients, however, had difficulties conceiving. Some succeeded in the first or second cycle of treatment. Pippa and Sean said:

Sean: And it worked on the first cycle.

Pippa: Yes, we were very lucky with that, because my hormones were already out then, though I didn't know it. They didn't say anything because I got pregnant. But they should have said. I was really cross about that. I thought they should have said something because then we waited 15 months before we started trying again, and now I can't get pregnant. If I'd have known, I would have tried sooner, because it's only got worse with time.

Pippa's experience raises the issue of the difficulty of becoming pregnant with advancing maternal age. Prue, the mother of two sons conceived by DI, claimed that it took longer to conceive as she grew older. She said:

Prue: I fell pregnant the first time with Jack, so...and the second time with Luke. And then I tried again for a third time and I think that took three times, so I think as time marches on, your body winds down. Like, I'm 40 now. Yeah, it definitely does make a difference. I lost that one anyway. And I didn't want to try again. I just decided it wasn't meant to be, so...yeah.

Prue's husband, Henry, who had been to the clinic for the inseminations for their first two children, did not attend with her for their attempt to have a third child. He said:

Henry: I went for the first couple of times and then I felt as though I had accepted the process and I didn't need to go. I wasn't backing off from them, I just felt, oh well, Prue's going off [for the inseminations].

Prue: And you never really know if he's going to be able to go or not [because of farm commitments]. I mean, it didn't matter. That was with the third time though.

While Prue did not attach any particular significance to her husband not attending the inseminations for her third conception, two other recipient women commented that their husbands had not attended the time that they became pregnant. Kathy, the divorced mother of two daughters, said:

Kathy: With Melissa I had three [inseminations]. I think she was my third attempt, and the first two attempts I went with Joel and the last attempt I went with a girlfriend and got pregnant the last time. I wonder is there some psychosomatic thing in there that you can do it without your husband's approval at the time? (she laughs) I don't know. I always thought about that. He wasn't there. It was the one time that he wasn't about that I did get pregnant. Because he had actually said to me, "That's the last time you're going." Again, he had made quite a directive statement at me. He said he'd go twice and he couldn't handle it after that. Joel, I think, wanted to move on. That was really where he was coming from I suspect. He was saying, if this doesn't work, no more. And there was a part of me that said, no, I'm going one more time, and I did and I had Melissa, so I'm glad I did.

For Kathy, it was significant that her husband Joel had not attended the inseminations the time that she became pregnant with Melissa.<sup>23</sup> Like Kathy, Carla, the separated mother of a daughter, said that her husband Ben was not present at the insemination that resulted in her pregnancy.

Carla: The last time, the time that I actually got pregnant with Justine, he didn't come. He couldn't face it anymore. He'd had enough. That was the ninth insemination. I had five different donors in those nine inseminations. And, at the time I got pregnant with Justine, there were only three donors, so there wasn't a heck of a lot of choice. And Justine's got beautiful big brown eyes, and both Ben and I are blue-eyed. We didn't even have a choice about that.

Both Kathy and Carla said that their spouses had reached a point where they did not want to continue with DI treatment, and thus continued treatment on their own. Carla's experience illustrates a situation of a loss of control, not only in relation to her husband's involvement (or lack of involvement) in the process, but also in terms of the number and choice of donors used during her treatment process.

### **Pregnancy and birth**

For most couples, the pregnancy and birth became a 'normal' event monitored by a midwife or general practitioner they had chosen. When asked what happened after conception, Alice said:

Alice: Immediately you think you are [pregnant], you contact them and they suggest you go to the GP for a blood test. And then, that was confirmed and then they book you for a seven-week scan

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<sup>23</sup> See Chapter Three for a discussion of the implications for Kathy of Joel not giving approval for her to proceed with the third and final insemination.

just to confirm the pregnancy and measurements, and then after that, because everything was OK, I went back to my GP for antenatal care.

Once a pregnancy was confirmed, some women resisted returning to the clinic and subjecting themselves to the medical 'gaze' of scans and monitoring devices (Lupton, 1997b:99). Patricia said:

Patricia: Well, they did encourage me to go back and have further scans and monitoring and things like that, just for it to become more established, but I'm independent really. I sort of felt that there needed to be a certain level of trust about it. I wanted to just trust that it would work out, that if it was conceived ordinarily, I probably wouldn't have known all those weeks, and that hovering around a monitor just didn't feel right for me, and I declined. And then, when I was three months, we contacted a professional. We went to a midwife, but we decided to do shared care with an obstetrician.

In contrast with the experience of 'normal' pregnancies, Meredith had on-going contact with the clinic because she suffered recurrent miscarriages, and, encouraged by the clinic nurse, kept returning for treatment. She was advised to have a few months' 'rest' in-between attempts to conceive and carry a baby to term. When asked if she was given a reason for her recurrent miscarriages, Meredith said:

Meredith: Well, no, that's the thing. There's no reason. Everybody just says, "oh no, not again," and that's it. They can't give you a reason why it didn't work. And also, I think even if they probably secretly know, I think they don't really want to say. People just sort of shut up, don't they? And all you want is answers and why and why? But you don't get any really...so they always kept in touch and said, "oh, we'll put you straight back on, whenever you're ready"...

This illustrates Cussins' contention that fertility treatment is open-ended partly because success is operationalised "not in terms of the child that the couple desires, or in terms of the particular problem to which the infertility is attributed...but in terms of the normal functioning of the woman as pregnant" (1998a:75). The lack of explanations for Meredith's recurring miscarriages also indicates that the uncertainty surrounding establishing the cause and effect of infertility creates an epistemic difficulty that is actively managed within the clinic on a daily basis so that it does not interfere with practice (Cussins, 1998a:76). Meredith's perseverance at the clinic's instigation also reflects the trajectory of the infertility narrative which typically begins with the woman as active subject relentlessly pursuing her 'dream' of parenthood who is then suddenly eclipsed by the more privileged point of view of the medical/scientific 'expert' (Franklin, 1990:211).

Some couples had more contact with the clinic throughout the pregnancy because they were having a multiple birth, one of the effects or 'risks' associated with fertility treatment involving the use of fertility drugs, such as clomiphene (Coney, 1999b:63). Jane, who was in her late thirties and was put on clomiphene to increase her chances of conceiving, was shocked to find out that she was carrying twins. She said:

Jane: Yes, twins. Such a shock really, and I remember [the doctor] telling me that, you know, don't be too worried if you don't end up with two. Um, so, I sort of had to keep that from anybody for a while until I found out how many I was actually carrying. I ended up still carrying the two of them.

In a bid to increase the success rates, clinics have contributed to the increase in multiple births (Coney, 1999b:63).<sup>24</sup> Multiple pregnancies increase health risks for both mothers and babies and quite often lead to miscarriage, premature birth and low birth weight (Coney, 1999b:63). Jane was told by her doctor not to expect to carry both foetuses to term. Ten weeks before the twins were due, she was hospitalised because one of the foetuses had stopped growing. Health professionals continued to monitor the foetuses in hospital for another five weeks and they were born five weeks prematurely. Justin weighed 6 ½ pounds at birth, but had to have a steroid injection to "kick-start" his breathing. Leanne weighed one ounce under 5 pounds at birth and, according to Jane, had to "fight for survival".

Like Jane, Sandra was taking clomiphene to increase the likelihood of success. She and her husband Allan had been told that on clomiphene she had a 10 percent chance of having twins if she got pregnant. The likelihood of having triplets was not mentioned. Sandra said:

Sandra: I knew at five weeks that I was pregnant. At eight weeks I could only do one skirt up. So I rang [the nurse] and I said, "I think I'd better have a scan". And she said, "funny you should say that. I just had you put on my list of things to do to ring and suggest you come in for one". And I said, "I can only do one skirt up," and she said, "OK, we'll make the appointment." The next day wasn't it? So we knew at nine weeks that we were having triplets.

KH: How did you feel about that?

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<sup>24</sup> Multiple births are associated with treatment cycles where a woman's ovulation is stimulated hormonally so she produces more than one oocyte. They are therefore more likely to be associated with IVF or GIFT treatment. Recent statistics reveal that multiple pregnancies occurred in about 20% of all IVF and GIFT pregnancies in Australia, compared with only 1.5% of all pregnancies (ACCESS, 2001). The two women included in this study who had multiple births were taking the drug clomiphene to stimulate the maturation of more than one oocyte during DI treatment cycles.

Allan: I was probably wearing a jersey like this. So I felt quite hot, and my hands started to sweat, and I had to take the jersey off. I was happy when he said there was one...that was great...there's two...that was even better...And then when he said there's three, I thought, "Uh oh, that's trouble", because my sister had lost twins.

Sandra: [The doctor] told me that first day not to give up work, not to hand in my notice because we could lose all three in the same breath. I've just heard actually in the last week that somebody lost them four days after finding out that she was pregnant with triplets, and I'm sure she was probably given the same kind of information: not to get too excited, because in the Multiple Birth Club there's actually quite a lot of twins that started out as triplets.

According to Coney (1999b:63), British HFEA statistics show that the stillbirth and neonatal death rate for a triplet pregnancy with one or more of the babies dying is 82.6 per 1000 births compared to 8.8 per 1000 for singleton pregnancies. Allan related his anxieties about the multiple pregnancy to his sister's experience of losing twins who were born prematurely. Allan and Sandra's triplets were born 10 weeks early: two girls weighed 2 pounds 13 ounces and a boy weighed 3 pounds 2 ounces. They were in neo-natal care for eight weeks.

Some recipients with singleton pregnancies also had to face a number of physical obstacles before achieving the objective of parenthood. Ella, the mother of three sons conceived by DI had previously given birth to a daughter who was stillborn.

Ella: I lost her at nine months. I was ready. The cord was around her neck and she just died. So there was nothing wrong with her. So basically she was full-term. I found out that she was dead and then I had to go through with the birth. It was all quite trying really.

Ella's experience is a reminder of the complications that can arise during the course of a 'normal' pregnancy, no matter how a child is conceived. According to Ella, the stress of losing this baby at full-term added to the stress of infertility, and she attributed the difficulties she had conceiving again through the DI programme to this.

For some couples, a difficult birth was a major source of stress. According to Carla, her husband Ben was "absolutely wonderful" and attentive throughout her pregnancy, but left her when their daughter Justine was 14 months old. She attributed this in part to the stress incurred by the circumstances of the birth and the early stages of Justine's life. She said:

Carla: The birth - the labour was 37 1/2 hours, very traumatic. Ended up a real mess. My case went to the inquiry at [the hospital]. It was the first one that went through the new system of inquiry. Everybody was rapped over the knuckles for the way that I was managed, and the state that I was in, so it was a very traumatic time for him. I sort of...you know how you are in

labour, you just labour on through it, 37 1/2 hours, and she ended up being born with an apgar<sup>25</sup> of 2, which is terrible, and had to be resuscitated and revived. Normally babies are born with 8 or 9, and she was 2. She was almost dead. The only thing she had was a pulse. She wasn't breathing, she was black, she was all floppy, and not very good at all. And that was traumatic for Ben. And then I was persistent to breastfeed because I really wanted to feel what it was like. So that was really traumatic and hard on Ben because I would sit and be very much in pain, and things. So it was a hard time.

The physical pain, bodily traumas and matters of life and death associated with the births and beginnings of life of babies such as the twins, triplets and singletons mentioned above, tended to overshadow any other concerns about having a child conceived by DI. Others, however, talked about their lingering concerns about this method of conception. Simon and Clare, who had a child biologically related to both of them before they conceived by DI, said:

Clare: Oh it was reasonably stressful at times. After the pregnancy was confirmed it got a bit tense, I suppose [she speaks tentatively]... between each other... all of the sudden it was very real, whereas before you were just going along to the clinic and yeah, it was sort of hazy in the future. Then all of a sudden it was a reality.

KH: So you felt some ambivalence about it did you Simon?

Simon: Mm. I think that's sure to say.

KH: You weren't sure if that was the right thing to have done?

Simon: Yeah, yeah. [The infertility diagnosis] has always been an uncertainty I guess. I mean, how come I ended up like that? So, yeah. Certainly coming to terms with the infertility I think wasn't the easiest thing really.

A pregnancy following DI conception also appeared to be a source of tension for other couples. Sarah said of her relationship with her husband:

Sarah: Tim says I push him into everything that we've ever got (she laughs). I pushed him into going onto the DI waiting list, pushed him into going for adoption and...that's on a bad day, you know...you're going to have bad days actually... And I would recommend any infertile couple or DI couple to kind of go to talk through this, because being a DI couple, you do wonder. Like, he hardly touched me when I was pregnant. And I was so consciously aware of it, like, was it because I was carrying another man's child, or was it because we were busy with Rob and Phoebe? Like we had lots going on and we didn't have an ideal pregnancy anyway. We didn't have any time to enjoy it.

Sarah indicated that Tim was ambivalent about having a child by DI. She was reminded of the tensions Tim felt after Charlotte, their daughter, was born. She said:

Sarah: ...a few weeks afterwards, everyone came around, "Oh, you know, this and that, and, oh she looks like you, or, oh gosh, what's going to happen now?" because Phoebe was only two months old so we were still pretty busy with her. And he just got really snotted off one day and he said,

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<sup>25</sup> The Apgar Test is performed on babies to rate their state of health when they are born. Each baby is given a number out of 10, 10 being the best outcome, and 1 the worst.

"I'm really sick of everybody asking about you and Charlotte. What about me?" I thought, "Oh shit." I said, "What about you? How are you feeling about all this?" "Oh, fine"(abruptly). It was just a reminder. And he was right. Even those that knew how Charlotte was conceived, were kind of careful not to say too much like, she looks like me, because that would offend Tim. But it was just all the... it was not like "Congratulations you're a father" sort of stuff.

Sarah was aware that she and the baby were the focus of attention from others and that the congratulatory remarks 'normally' bestowed on new fathers were not forthcoming. This situation raises the issue of whether, in situations when donor sperm is used, men's sense of being marginalised and alienated from the processes of conception, pregnancy and birth could be heightened. As previously discussed, research has shown that male partners could feel marginalised in fertility treatment because women's bodies are the primary focus of infertility investigations and men often play, or are positioned to play, a passive role in the treatment process (Meerabeau, 1991).

Other men said they experienced ambivalence when their child conceived by DI was born. Andrew said:

Andrew: I was quite a cruel father at baby time because when Annie had Hayley, I buggered off and played a lot of golf, got very involved with the golf club and still am. But I don't drop the family now like I used to. I didn't with Annabel.

Annie: That was a big problem at the start.

Andrew: I'd just go at the weekends, that was it. I played representative golf. Right into it, and wasn't around. Non-supportive. Not my kid...

Annie: Which led to me getting depression, post-natal depression I guess it was.

Andrew: ...which was pretty hard on the other spouse.

Andrew had wanted to distance himself from a situation where he felt reminded that he was not the genetic father of his child. He had also found it uncomfortable confronting situations when others commented that the baby looked like him which served as a similar reminder.<sup>26</sup>

While some men were ambivalent about the birth of a child conceived by DI, some women said they found it difficult carrying a child who was, in a sense, as Sarah had also suggested, "another man's child". Kathy said:

Kathy: It was extremely difficult for me being pregnant too, I'd have to say. I didn't have anyone at the time other than I sought my own counselling again, because I realised I was pregnant with someone else's child. I mean, to me I had an unknown quantity there that I knew nothing about. I just... yeah, it was just that whole unknown quantity. I thought, "well who is this?...there's a whole part here that I know nothing about." It's like having a blind pregnancy. I thought, "I'm half of an issue."

Like Kathy, Annie was anxious about carrying a child 'fathered' by a man she had never seen or met. She and Andrew said:

Andrew: The only fear that we had was that it would come out Chinese, Maori or Samoan (Annie laughs), some nationality that wasn't where we'd come from, sort of thing. That was a pretty light-hearted joke, but it was driven by fear and the closer to birth time the more heightened the fear was from Annie's point of view.

Annie: In fact the first thing that we did when we saw Hayley is, I said, "Oh good, it's not Chinese." (we laugh). And the midwife wouldn't have had a clue what we were talking about; only the doctor did.

Andrew and Annie's fears that the child would look ethnically different from them highlighted their over-riding concern with secrecy about their children's DI origins and wanting to 'pass' as 'normal' parents. It also highlights that, with the use of an anonymous donor, couples having babies may have more uncertainties about what they are 'getting'.

While heterosexual couples could attempt to 'pass' as the child's biological parents, lesbian couples had to explain to others that they were expecting a child which challenged normative understandings of the family. By conceiving a child, lesbian women were disrupting notions that, by foregoing heterosexual relations, they were relinquishing the possibility of having children. The lesbian couples interviewed for this research said that some of their extended family members were challenged by the notion that they were 'creating a family'. When Ria and Sophie decided to inform Sophie's parents that Ria was expecting 'their' child, they invited them out to dinner to tell them the good news. They said:

Sophie: We hadn't told them that we were thinking of getting pregnant, and once we were pregnant...it was about two months down the track...we invited them out, and we went out to dinner and bought a bottle of champagne... We were a bit nervous about telling them. And I finally told them, and they just went [she stares incredulously] (she laughs). That was their initial reaction.

Ria: Silence for about five or seven minutes.

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<sup>26</sup> See Chapter Eleven for a discussion of physical resemblance between parents and babies, which becomes a particular issue in the context of DI.



Sophie: And Ria hid behind the menu (she laughs). And I went ‘blah blah blah’ and raved constantly for about five minutes.

Ria: It was *terrible*. ...It would have been better to let them know that we had been trying, which you [Sophie, who was now planning to get pregnant] have to tell them again. But once we explained to them the dynamics of where Derek will come into it, and that Sophie will apply for legal guardianship, and we had to explain a bit of how it was all going to...how our family was going to be made up really. We think Sophie’s mother went away thinking, “what are people going to think?” Well, we heard from Sophie’s sister that her mother was saying, “but what will people think?”

Sophie and Ria’s narrative shows that while they wanted to celebrate and share their exciting news with family members, Sophie’s parents had not anticipated and were completely unprepared for the event. Sophie’s mother’s supposed concerns about what others might think about her daughter’s situation reflects general public perceptions that “for socially acceptable women, biology should be destiny, whereas for socially unacceptable women, the demands of biology should be restricted by social sanctions” (Franklin, 1990:208). Nonetheless, after their initial shock, Sophie’s parents appeared to have accepted her chosen family arrangements. Ria said:

Ria: Yeah, it was just the initial shock, because they came four hours after Lydia was born. They were there with flowers and champagne, and they very much...she’s their granddaughter.

Derek<sup>27</sup> was involved to some extent in the pregnancy and birth of their child. He had attended the session when they had a scan, home birth classes and was present at Lydia’s birth. He said of his involvement in the birth:

Derek: I had two feelings about being present at the birth. I would like to be, but it was also a really good time that Sophie could enjoy without me being there to give her a stronger bond with the child. Just her and Ria could be alone to have the child. They didn’t agree with me on that. They wanted to have me there, but when it all started to happen quite quickly...when my mother was born, her mother died at the birth, and I was struggling a little bit just to see somebody that I love dearly going through the same scenario. So it was quite good that I was out because I was a little bit panicked. I had to take time out for myself to go for a bit of a wander. I was just aware that [it could go wrong] and it has happened in my family before.

At the birth, Derek was negotiating multiple subject positions: as ‘father’ of the child, ‘sperm donor’ to a lesbian couple, and grandson of a woman who had died in childbirth. When the birth became an emergency caesarian section, he was more comfortable “pacing the hallways” of the hospital, thereby adopting the position of

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<sup>27</sup> As discussed in Chapter Ten, Ria, Sophie and Derek consider Derek to be the ‘father’ of their daughter, rather than their donor. While he is not legally the father of their child and does not live with them, he is the genetic and social father.

the nervous prospective father, at a distance from the mess and trauma of a difficult birth.

### **Follow-up with the clinic**

For those who had conceived through a fertility clinic DI programme, there was no systematic followup from the clinic staff. When asked if there was any on-going contact between the clinic and recipients of DI, the director of a DI programme said:

Dr C: No. There's not. There was a major contact done with the fifty couples that we researched...but, no, there's no contact.

KH: Do couples come back with their child or send photos of their babies?

Dr C: Yeah, heaps of photos.

Dr C's comments highlighted the clinicians' primary concerns with clinical outcomes and research, and also reflected the gendered division of labour. While officially there was no on-going contact between this clinic and recipients after they had conceived through the programme, some forms of reciprocal exchange and gift-giving did take place, particularly between clinic nurses and mothers of children conceived by DI. This illustrated that women, who were nurses, counsellors and lab technicians, rather than men who primarily were doctors, maintained a role as 'carers' after babies were born.

Several mothers reported contact with a clinical nurse after their baby's birth. When asked if she had any follow-up with the clinic, Tania said:

Tania: No. Oh yes, [the nurse] called me about Christmas time because I was meant to go in and show him off. Yeah, she did call me to see how it all went, to see if I wanted to stay on the programme. She asked me to bring him in so they could see him. He was called a number, which didn't impress me very much when she took him round to show the technician.

KH: She introduced him as a number, really? (we laugh)

Tania: But that's just the sort of person she was. She's lovely. They're very, very caring people actually. But when I got pregnant I did my pregnancy test with her, and she cried, I cried. And I said, "What do I do now?" And she said, go to your doctor, your GP.

Tania depicted the clinic nurse as someone with whom she had developed a rapport, who was emotionally invested in her getting pregnant and having a baby, but was also a health professional tied to certain clinical practices. When Tania brought her baby

in, the nurse introduced him to the lab technician by the number attributed to him through clinical practices. This illustrated how anonymity is ensured and how identities are constructed in particular local sites, such as workplaces.

In contrast to this DI programme's practices, the other South Island DI programme retained a form of contact with recipients through an annual newsletter which is separate from the donors' newsletter. A nurse said:

Nurse A: We've always sent out annual newsletters to our couples, just to update them on what's been happening during the year and how many babies have been born. Now that we're under the [fertility clinic], the [clinic] sends out a newsletter to all its patients, and we've got a wee slot in there. In that last one we mentioned that there's a support group interested in getting together; if people wanted to access that, they could. I think it's important to still let couples know we're here, and we're still interested in what they're doing. We also keep records of them on the computer and one of the questions on the computer is "do you want to be on the mailing list?" Usually they do, but more recently I had a couple who said they received the newsletter, but they said that they felt that they'd been through the programme and they don't want to have any more news about what's going on, so they asked to be taken off the list. So that's a personal choice. But, we always enjoy feedback from couples, we always enjoy when they come back with their babies or their children, or come in with photographs. We find it the most rewarding part of working in the area.

Several recipients said they had sent photos or taken their child in to visit the nurses.

Meredith said:

Meredith: [The nurse] used to come around. She came and brought a present for Daniel, and [another nurse] used to keep in touch, and then I used to take Christmas cards in every year, and last year, I hate to admit, was the first year I haven't. Daniel used to take a Christmas card in to them. Just quickly, just to say hello and just to say thank you, I'll never forget you, and I still appreciate what you did (hah). And even though I don't see them, I still do appreciate it.

Her appreciation, it seems, was for the gift of Daniel's life. Other recipients spoke of the visits they had received from nurses in the hospital after the baby's birth. Ella, who had given birth to four babies conceived by DI, said:

Ella: I was on the same floor so they used to wander down, and they always had a whole lot of booties. They always give you a pair of booties with each baby, and a card. You get to know them up there because they're like family. They're nice people, and Dr A's lovely.

The gift of a pair of booties for the baby is a symbolic gesture recognising the arrival of the new life clinic staff had played a part in creating. While attending the clinic over several years, Ella felt she had developed close relationships with the staff, to the extent that they had become "like family".

Some mothers said that they had not received a visit from clinic staff because they had given birth at some distance from the clinic, but several had taken in their child to show clinic staff. Clare had visited the clinic nurse after she found she was pregnant again, this time without the clinic's assistance. She said:

Clare: I took Maria in and I was chatting away, and [the nurse] said did I have any questions over the last 12-14 months. And I say, um, just one. And she said, "oh what's that?" And I said, "well, can you tell me why I'm four months' pregnant?" "Oh!" [her jaw drops]. You know (she laughs), she was a wee bit surprised! It was a shock to us. It was more of a shock to [the nurse], and she went away and she got our file out and, she said, "what were you told?" And I told her. And she said, "oh that's not quite what I would have said".

Clare asked how she could have become pregnant when they were told by a specialist that they had very little chance of conceiving without donor sperm. Having checked their file, the nurse informed Clare that she would have interpreted Clare's husband's results differently, giving them a better chance of conceiving together, thus challenging the specialist's interpretation. This raises the issue of the uncertainties surrounding determining the likelihood of pregnancy in cases where men are oligospermic, and the variations that can occur in the interpretation of medical test results.

Some couples had initiated contact with the clinic themselves when they wanted to conceive another child. Others contacted the clinic when their child was chronically ill to find out if the condition could have been inherited from the donor. Kathy was unable to find out any information about the donor to shed light on her daughter's medical problems. She said:

Kathy: When she was born I asked for more information. When she was sick we asked for more information. She had renal reflux and they wanted to know did anybody else have it. What else was there that we needed to know? We had nothing.

In contrast to Kathy's situation, Joanna, the mother of Todd and Jessie, said about her contact with the clinic:

Joanna: I actually went in because they sent me out information about the donor and I went in and gave them a photo, because they like a photo of the children when they're born to put up on their board. And when Todd was sick, they were really good. They actually got hold of the donor and his family history to see if what Todd had was through his side of the family. They were quite good then, because at that stage there was nothing about great-grandparents, or grandparents, but now, when Jessie was born they had got all that information.

In Joanna's narrative, her son Todd occupies two contradictory subject positions: as a symbolic representation of the 'success' of DI programmes and a problematic DI child with unexplained chronic illness. When Todd became ill, Joanna had contacted the clinic which had looked into the donor's medical history to find out if his illness could have been attributed to a predisposition inherited from the donor. From what they could find out, this was not the case. Joanna had sent the clinic photos of her children because she knew that they liked to 'advertise' to other prospective DI recipients the products of their shared labours. By displaying the symbols of their shared achievements, the clinic strategically involves successful recipients in the public face of the clinic in the bid to attract future business.

### **Conclusion**

The chapter has illustrated how recipient couples negotiate the roles of 'client', 'patient' and 'would-be parent' in interaction with clinic personnel who adopt different subject positions and roles in the clinical setting. Having been accepted for DI treatment, couples have to conform to clinical protocols and procedures in their bid to achieve the successful outcome of the normal pregnancy trajectory. Women's bodies are the focus of treatment, which appeared to have the effect in some cases of marginalising men in the treatment process. This relates to debates in the literature about the biomedical focus on establishing the normal pregnancy trajectory in women (Cussins, 1998a) and men's marginal role in this process (Meerabeau, 1991). This in turn, raises the issue of the need to include men, addressing their specific needs, so they do not feel excluded from the process of conception. It also highlights the gender issues associated with the different roles in reproduction.

Gender issues were also apparent in the division of labour in the clinic. Female staff members were positioned to provide care and support to clients in the roles of nurse or counsellor, and men, held positions of power as doctors and clinical directors, taking a more instrumental, outcome-focussed approach. All couples attend an initial consultation with the clinical director, a physician who oversees each couple's pathway through the clinic, changing treatment protocols if and when deemed necessary to achieve a successful outcome. Clinical directors also attend to the required formality of gaining informed consent from couples, determining if DI is the 'best' option for each couple, enlisting the help of counsellor as required. Female

nurses educate women in the practical and technical aspects of the monitoring and surveillance of their menstrual cycles, and perform or oversee inseminations.

The chapter has engaged with the debates around the role of counselling in fertility treatment programmes (see for example, Daniels, 1993; Walker and Broderick, 1999a, 1999b; Daniels, 1999c), outlining its three separate functions: information giving and discussion, therapy and support, and assessment or screening. Counselling is generally constructed as information giving, but also involves elements of assessment and therapy. Because the role of the counsellor is not clearcut, and recipients' needs vary, some have been resistant to counselling. If they saw a counsellor, couples generally attended the one recommended counselling session only. Counsellors working in DI programmes claimed that if they saw couples more than once, it was because they were experiencing stress about some aspect of treatment, at which point they assumed a therapeutic or support role. The question arises whether this was adequate to address matters such as some men's on-going concerns about infertility, and other psychosocial issues that might arise after DI conception.

Several comments made by men highlighted their continued marginalisation throughout treatment, during pregnancy and after the birth of a child conceived by DI. Some clinics actively included men in the treatment process by enabling them to carry out the inseminations, thereby constructing themselves as 'inseminator' and 'father' of the potential child. Similarly, non-biological lesbian mothers constructed themselves as a parent of the child through their active involvement in the conception process. Partners' reported positive experiences of involvement in the insemination procedures, suggests that this may be a helpful way of including prospective fathers/parents in the procreative process. Such involvement might also help alleviate some of the distressing aspects of inseminations reported by some couples. Concerns and anxieties expressed by couples in this chapter raised questions about the possible need for follow-up of couples to address some of the psychosocial issues that emerge for couples after the birth of a child conceived by DI. These issues have implications for the formulation of policy and practice in this area.

After conceiving, couples' pregnancies were generally constructed as 'normal' events to be monitored by maternity caregivers chosen by the couple. Formally, the

relationship between the clinic and recipient couple ended after the entry into the normal pregnancy trajectory, but contact or follow-up occurred in ‘exceptional’ cases – during multiple pregnancies, after miscarriages or stillbirth, or if babies were sick. At one clinic, nurses visited women and their babies at the hospital after their birth, bearing gifts and sharing in the celebration of their mutual success. Couples were also enrolled or voluntarily participated in sharing in the public face of the clinic’s DI programme by sending photographs of their babies to be posted on the bulletin board, thereby advertising the products of their mutual labours, and enticing others to follow suit.

The negotiation of clinical worlds for DI recipients is multifaceted. While inhabiting these worlds prospective parents interact with different clinic staff all of whom adopt different subject positions with regard to educating, evaluating and caring for recipients. For recipients, the process of trying to conceive a child by DI involves negotiating a number of shifting and changing identities as paying client, worthy prospective parent, compliant patient, and active agent. After entering into the normal pregnancy trajectory, couples had to negotiate the uncertainties and challenges surrounding carrying one or more foetuses to term and, for many, the ambivalences about bringing into the world a child conceived with the help of an unknown sperm donor.

## PART THREE

### **Negotiating Relationships after DI**



### **Preface to Part III - Negotiating Relationships after DI**

This section of the thesis examines the implications of the birth of a child conceived by DI for relationships within families and between family members and others. The first chapter looks at the issues of secrecy, privacy and disclosure about a DI conception in the context of increased criticism of secrecy about DI and arguments that favour information-sharing. The chapter indicates that patterns of secrecy and disclosure are complex, ambivalent and embedded in particular social and relational contexts that shift and change over time.

Parents' attitudes and actions in relation to telling or not telling their children how they were conceived are the focus of Chapter Nine. The chapter examines the socio-political context of information-sharing about DI in New Zealand, and the dominant discourse of the 'right' of the child to know his/her genetic origins. Most parents had told their children when they were quite young, but some were waiting for the 'right time' to tell. Only one parent claimed to have no plans to tell her child about his DI conception.

Chapter Ten explores the attitudes of parents and their kin towards donors. Several parents, particularly mothers, claimed to be grateful to the donor for his 'gift', and some reciprocated by sending donors anonymous thank-you letters, and photographs of their children, or planned to become egg donors. Participants' attitudes towards donors varied. Some were in favour of preserving anonymity, while others claimed to have become more curious about the donors over time, anticipating that their children might wish to contact them in the future. Women who were no longer living with the social fathers of their children were most likely to express an interest in meeting the donors and incorporating them in some way into their lives.

Chapter Eleven argues that, like all families, 'DI families' are diverse rather than unitary. The chapter examines the variety of ways that these families respond to some of the complex and contradictory issues and uncertainties that emerge for relationships within families and with others as a result of conceiving with the help of an unknown but potentially knowable sperm donor.

## Chapter Eight

### Secrecy and Disclosure

Secrecy is as indispensable to human beings as fire, and as greatly feared. Both enhance and protect life, yet both can stifle, lay waste, spread out of all control. Both may be used to guard intimacy or to invade it, to nurture or to consume. And each can be turned against itself; barriers of secrecy are set up to guard against secret plots and surreptitious prying, just as fire is used to fight fire (Bok, 1984:18).

#### Introduction

Donor insemination, as primarily a medical ‘treatment’ for male infertility, has traditionally been shrouded in secrecy (Rowland, 1985; Daniels and Taylor, 1993a). Over the past two decades, however, the secrecy surrounding DI has been strongly criticised. This has been fuelled by the trend towards open adoption and the accompanying discourse about the ‘right’ of children to know about their birth/genetic origins (Rowland, 1985; Corcoran, 1988; Rockel and Ryburn, 1988; O’Donovan, 1989; Berry, 1991; Van Keppel, 1991; Daniels and Taylor, 1993a; Blyth, 1999).

Contributors to debates about secrecy and ‘openness’ (now more commonly referred to as ‘information-sharing’)<sup>1</sup> include social workers, psychologists, other mental health professionals working in the field of infertility counselling, other social scientists, and increasingly parents who have conceived children by DI, individuals conceived by DI, and some donors (see, for example, Snowden, Mitchell and Snowden, 1983; Achilles, 1989, 1993a; Baran and Pannor, 1989; Daniels, 1988, 1995, 1997; Daniels and Taylor, 1993a; Daniels and Lewis, 1996b; Schaffer and Diamond, 1993; Landau, 1998; Blyth 1998, 1999; DCSG, 1997). Health professionals working in the field of reproductive medicine have also contributed to the debate about secrecy and disclosure, particularly in relation to the attitudes of parents towards telling their children about their DI conception (Nachtigall, 1993; Leiblum and Aviv, 1997;

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<sup>1</sup> The shift away from the use of the binary terminology of secrecy and openness and words such as anonymity, confidentiality and privacy to ‘information-sharing’ or ‘exchange of information’ reflects a move away from controversial, value-laden language and binary logic (Daniels, 1995; Daniels and Lewis, 1996b).

Nachtigall et al, 1998; van Berkel et al, 1999). Philosophers, such as Pennings (1997, 1999, 2000), have also made a significant contribution to this debate.

Advocacy of secrecy in the context of DI is seen to revolve around forms of protectionism and, in some cases, medical paternalism (Rowland, 1985; Daniels, 1995:220). Daniels and Taylor (1993a:157-158) suggest that the main reason for advocating secrecy, given by those involved, is to protect the child from psychological or emotional trauma, and from being stigmatised. Secrecy has also been viewed as a means of protecting the donor from possible unwanted contact and disruption to his family life. Secrecy provides a means of protecting the medical profession from adverse public reaction to DI (Haines, 1993b). Others have suggested that secrecy primarily protects the recipient couple, and particularly the infertile male partner, from the shame of male infertility (Daniels and Taylor, 1993a:157). Secrecy and anonymity are viewed by some as protecting the social and psychological construct of the family resulting from gamete donation, especially enhancing the social paternal role of the male in the recipient couple (Shenfield and Steele, 1997; Shenfield, 1997). Haines (1990) draws attention to the way that DI policies and practices protect the ideology of 'the family'. Shenfield (1997:372) argues, furthermore, that anonymity allows couples "to keep the 'artificial' means of conception of their child a secret if they so wish", that this wish should be respected, and that no evidence suggests that secrecy is deleterious to the child.

In contrast, those who favour information-sharing argue that secrecy is inherently harmful because it primarily protects the interests of those who have power to control the flow of information. It is particularly harmful, they argue, for those who are deprived of information that might be significant to them (Daniels, 1995:220). Advocates of information-sharing thus draw on rights discourses that compete with those invoked by proponents of secrecy and anonymity. In particular, they draw on arguments about the 'right' of the child to know his/her genetic origins (Daniels and Taylor, 1993a). As discussed in Chapter One, in the New Zealand context, the 'best interests of the offspring' of assisted reproduction, including the 'right' to know one's genetic origins, are constructed as paramount (MCART, 1994). Openness was recommended by MCART on the grounds that it better protects the rights and responsibilities of both Maori and non-Maori, and that secrecy could not be justified

legally<sup>2</sup> or culturally (1994:71-92). With respect to the latter, the concept of *whakapapa*, a notion of genealogy based on the knowledge of one's genetic origins, is a significant aspect of Maori culture (MCART, 1994:2-33). Thus, in New Zealand, pressure is brought to bear on parents to be 'open' rather than secretive about conceiving a child by DI. Other countries considering the implications of AHR, like Canada, have also implemented the same guiding principle (Daniels and Lewis, 1996b:60).

In defence of a philosophy of 'openness' or information-sharing (Daniels and Taylor, 1993a:160-161), protagonists of 'openness' in DI also invoke arguments about the potential harm to families of harbouring secrets, and DI offspring 'accidentally' finding out the 'truth' of their genetic origins (Landau, 1998). It is argued that this is also more likely to happen in contemporary western societies where access to genetic information is becoming more widespread. Underlying the argument about the harm caused by secrecy within families, however, appears to be a general assumption that family and kin relationships are based on openness, trust and honesty. However, Haimes (1993b) points to the lack of empirical evidence that 'ordinary' families operate in this way. They may function instead, Haimes suggests, "on knowing when not to say something or when not to ask about certain matters" (1993b:179). For this reason, Haimes (1993b) maintains that the question of secrecy and openness in DI needs to be seen in the context of the full range of possible family interactions.

Haimes (1993) also questions the premise she infers from Daniels and Taylor's (1993a) argument that openness and truth are unproblematically "good" and secrecy is unproblematically "bad". This illustrates the way that the binary concepts of secrecy and openness are equated with yet another simplistic and problematic dichotomy. Haimes cites Bok (1984), for example, as disputing such claims. Bok (1984:20) argues that all human agents seek a degree of control over secrecy and openness as a means of preserving autonomy, freedom and, ultimately, survival. Bok also identifies the dangers of secrecy, and that the experience of secrecy is conflicted

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<sup>2</sup>MCART (1994:72) suggested that information about gamete donation was probably "health information" as defined by the Health Information Privacy Code 1994, and section 22B of the Health Act 1956, and therefore part of the "medical history" of the child conceived by DI. More controversially, the committee suggested that the identity of the donor might also be considered health information about the child.

and ambivalent. She argues that conflicts over secrecy are conflicts over the power that comes from controlling the flow of information (Bok, 1984:19). Thus, she claims, the issue is not secrecy itself, but rather the control over secrecy and openness (1984:23).

In view of these arguments, this chapter presents and investigates empirical evidence about how couples (and their kin) manage the flow of information about DI, and the relational contexts within which they tell or do not tell others about their child's DI conception. Rowland (1985b) has argued that talk of 'protection' and 'rights' is not the most useful approach to secrecy and information-sharing in the context of DI. Instead, she maintains that the situation for all parties concerned needs to be considered and, to do that, the co-operation of recipient couples is needed in research in this area (Rowland, 1985:395-6). The chapter thus examines the range of practices with respect to secrecy and disclosure adopted by the families in the study with children conceived by DI. The complexities, contradictions, conflicts and ambivalences that emerged, particularly for parents, are a focus of attention. While it has been suggested that there are degrees of privacy and disclosure (Daniels, 1997), I consider that secrecy and disclosure are more usefully conceptualised as embedded in particular sets of social relations. For example, people are more likely to disclose private information about themselves to people they trust and with whom they share close ties, than to those they do not trust or from whom they are estranged. Thus, the sharing or withholding of information takes place in the context of particular relationships that shift and change over time. The chapter traverses the sequence of events from diagnosis of infertility to the birth of a child conceived by DI. While some issues about telling the child of his/her genetic origins emerge in this chapter, that topic is more specifically addressed in Chapter Nine.

### **Keeping Secrets**

The issues that emerge for couples in relation to telling or not telling others about the use of DI to conceive a child or children are complex and can have significant implications for relationships, particularly in the context of family and kin relations. For couples considering conceiving by DI, the discovery of infertility may be accompanied by a desire for secrecy, particularly in the initial stages. Several researchers in the field of infertility have indicated that infertile men are reluctant to

talk about their infertility which has led to them being under-represented in studies in this area (Sandelowski, Holditch-Davis, Harris, 1992; Daly, 1992; Lloyd, 1994). Infertility researchers point to a belief that male infertility is viewed more negatively and carries a greater stigma than female infertility because of associations made between male virility, sexuality and procreation (Rowland, 1985; Miall, 1986; Baran and Pannor, 1989:25). Secrecy has, therefore, been regarded as a means of protecting a man from the stigma of male infertility, and as a means of creating the 'illusion' of a biological connection between him and any children conceived by DI.

Several men interviewed for this study indicated a desire, at least initially, to keep their infertility a secret to protect their self-image and to avoid the stigma attached to male infertility. Most were able to discuss their infertility with their partners and sometimes with other close family members. However, Andrew, the father of two daughters conceived by DI, was so distressed about his inability to reproduce that he had refused to discuss it, and wanted their use of DI to remain a secret. He and his wife Annie said:

Andrew: We did get opinions, but at the end of the day it's become...

Annie: *Andrew's* choice.

Andrew: *My* choice.

Annie: Which I don't actually agree with.

Andrew: My choice, that I chose not to talk about my condition to anyone. None of their business.

KH: But you've obviously had a lot of difficulties with it personally.

Andrew: Yeah. More than I anticipated.

Andrew found it difficult to discuss his infertility even with Annie, who recalled the consequences for their relationship:

Annie: We weren't talking at that time. We weren't talking about it at all. It was just something we didn't do. I couldn't say anything to Andrew. I mean, he just didn't want to talk about it, and that was all there was to it, which was really a hard time. We've got through that and that has made us stronger, but I mean, at the time, it was very difficult, especially because you couldn't go and tell your friends. If I did that I was being disloyal to Andrew. And that was quite hard.... Men are different. They don't talk about these things as much.

KH: So you felt you were protecting Andrew?

Annie: Yes. Very much. In fact I actually...I didn't lie to people, but I indicated that the problem was with me.

Annie attended to Andrew's 'needs' rather than her own. She even implied that she was the cause of their need to seek assistance to conceive. Other researchers have found that it is not uncommon for women with infertile male partners to protect their partners in this way (see Snowden, Mitchell and Snowden, 1983; Sandelowski and Jones, 1986; Baran and Pannor, 1989:24-26). Annie indicated that telling outright lies would be wrong, but she nonetheless sought to avoid telling the truth because of what she construed as her primary obligation to abide by Andrew's bid for secrecy. This illustrated an important distinction between telling lies and keeping secrets: while Annie was comfortable telling 'white' lies and half-truths, she would not have found it morally acceptable to actively tell a lie (Bok, 1978:57-61).<sup>3</sup>

Despite her desire to be able to confide in a friend, who herself was infertile, Annie had managed to maintain their secret.

Annie: I think my friends, well, one of them thinks that I've used somebody else's egg. She's asked a lot of questions, and put things together, but hasn't come up with the right answer. I've just told her that it's not my place to say anything. This is a friend that I see every day. We're very close. We're very, very close, but not close enough where I'd be able to sit down and talk to her, because I'm so loyal to Andrew (she laughs).

Annie revealed a tension between her loyalties to her husband, to herself and to her friends. The resolution of one tension thus created another. Annie said:

Annie: I'm not desperate to go out and tell somebody, sort of thing. Now I've got through all that, it's not crucial, but yes, I think it would be nice to be able to confide in people. Because you're not being totally truthful to people, and I think it shuts them out a wee bit. And I think that probably good friends we know do feel that.

Annie was particularly uncomfortable that Andrew had refused to tell his mother about her granddaughters' DI conception, and regarded this as a form of deception. She said:

Annie: Whether I'm right or wrong, I don't know. *I feel like we've cheated your mother.* Every time I see her with the kids, I think "we've cheated you by not telling you this." But Andrew sees it quite differently, so we're quite different on those issues.

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<sup>3</sup> Similarly, in their study of families with children conceived by DI, Snowden, Mitchell and Snowden (1983:104) also found that couples generally wished to avoid telling lies about their donor conception.

Andrew did not think that he was deceiving his mother. He argued that she simply did not know about it which was different. He conceded that he suspected that his mother had “a bit of an idea” about it, but would respect his wishes to tell her when he felt ready and, at the current time, he did not feel ready. This situation raises the issue of the varying interpretations of the concept ‘secrecy’. It also suggests that different interpretations and approaches to secrecy, in this case around DI, may be a source of stress for couples with differing perceptions. Bok (1984:7) highlights the distinction between secrecy and deception.

The link between secrecy and deceit is so strong in the minds of some that they mistakenly assume all secrecy (especially when protected by silence) to be deceptive... To confuse secrecy and deception is easy, since all deception does involve keeping something secret... But while all deception requires secrecy, all secrecy is not meant to deceive. Consider the many forms of secrecy in which there need be no aim to mislead: that which may accompany human intimacy, for instance, or protect voters in casting their ballot (Bok, 1984:7).

Bok (1984) recognises the different shades of meaning attached to the word secrecy including whether something is sacred, intimate, private,<sup>4</sup> unspoken, silent, prohibited, shameful, stealthy, or deceitful. For this reason, Bok (1984:7) argues that “it would be a mistake to define secrecy in terms of one or two of these meanings, or to view it too narrowly by assuming from the outset an evaluative stance either for or against secrets in general”.

Psychologists Lane and Wegner (1995:237) note that studies have shown that keeping secrets appears to be associated with psychological distress, and that families in which an important fact, such as abuse or parentage, has been kept secret over the years will often show dysfunctionality related directly to the secret. At the time of the interview, Andrew had reached a stage where he had begun to believe that secrecy was creating too much stress for himself, Annie, and their marriage, and that he had resolved to become more ‘open’ in the future.

Andrew: I'm a very closed person, and I've learned that I've got to open up a bit, otherwise you just get ulcers and stuff. Your body goes to bits (he laughs), which can kill you, I guess, if you do it too long. Stress is a great thing, I live on stress, but not that much.

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<sup>4</sup> The concept of privacy, which is closely related to secrecy, is discussed in the next section of this chapter.



Andrew became more conscious of Annie's distress relating to his refusal to address the emotional issues in relation to his infertility and their use of DI,<sup>5</sup> after Annie staged an exhibition of her art works, which depicted different forms of emotional expression. Andrew said:

Andrew: Annie's emotions come out in [her art]. And it wasn't till people who came to the exhibition said, "You've got a very stressed wife." They could see her stress, because she'd done a piece ... and all her figures had great emotion: stress, anger, all those things.

Because Annie had felt unable to talk to anyone about the issues surrounding infertility and DI, she turned to art as an 'outlet' for her emotions.

One of the 'trade-offs' of maintaining secrecy about infertility and fertility treatment is cutting oneself off from sources of support (Menning, 1980). Some mothers of children conceived by DI expressed the emotional 'need' to tell close friends or family about their infertility and the way their children were conceived, even if their partner was unwilling to discuss it with anybody. Like Annie, Jane, the mother of twins conceived by DI, also talked about the tension between the perceived need to keep DI a secret and her emotional need to tell. She commented:

Jane: I've sort of had that block from the beginning that I sort of felt that I would have liked to probably have seen it as being the norm, rather just sort of keep it to myself, because I felt that I would have liked to have shared that with other people. So I do find that really difficult. It's because I sort of feel that by keeping it to yourself, you actually... it actually stops you from going forward in some ways.

Jane's feeling that she ought to keep her experience of DI a secret illustrates how notions about what constitutes a 'normal' family have inhibited disclosures about DI (Achilles, 1993a). Jane revealed a tension between believing that conceiving a child by DI was not the 'norm', and therefore should not be shared with others, and a desire to tell others as part of the process of accepting it (i.e. making it 'normal') and 'moving on' with her life. Although she believed Steve, her husband, had not disclosed to others, Jane said she had told some of her friends about their children's DI origins.

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<sup>5</sup> For further elaboration on Andrew's reactions to his infertility, including his suicidal feelings and loss of a sense of purpose in life, see Chapter Four.

Jane: I don't think Steve's ever told anybody. I have. I have told about four or five friends, and they were really good about it. I just sort of blurted it out really I suppose. I find it really hard not to talk to people about it. I find that I really do need to have, yeah, contact with people. I sort of feel that you can't talk...because you actually go through a situation of having a donor, I sort of feel that you're different, I mean, different from other people because you don't just have the children naturally, so it will immediately, yeah, I sort of feel from the beginning, you're in a different situation.

Jane was caught between two conflicting imperatives: on one hand, the desire to keep her children's DI conception a secret for fear of social retribution; on the other, she felt the need to tell others her 'secret' and found that keeping the secret was extremely burdensome. Jane said that she found secrecy to be the "worst thing" about having children with the use of DI. Psychologists Lane and Wegner (1995) argue that keeping secrets is a dangerous and difficult business because it requires hard work. They maintain that when it is important not to disclose the secrets, "secret-bearers must work strategically to make sure that their verbal and non-verbal behaviours do not give away the hidden information" (1995:237). Lane and Wegner propose that secret-keeping sets off cognitive processes that result in obsessive pre-occupation with the secret. They hypothesise that suppression of a thought makes the thought *more* accessible to consciousness and, therefore, leads to outbursts in which the secret is disclosed. This hypothesis might in some way account for Jane's tendency to occasionally "blurt out" her 'secret'. However, the focus on individual cognitive processes neglects the social context in which the secret is disclosed, and does not explain why keeping a secret can be distressing for some people and not others. In Jane's case, as in Annie's, she was placed in the ambivalent position of wanting to share her important experience with friends, while knowing that Steve did not want her to do so.

Steve appeared to be more distressed by the fact that he knew Jane had told others than by keeping the secret himself. He feared being socially ostracised by family members and friends if they found out that their children were conceived by DI. He was especially concerned that they did not tell Jane's parents because they had rejected Jane and Steve's relationship in the past by refusing to attend their wedding.

Steve: I don't think that your parents... your parents at the time, because of the climatic conditions [their relationship with Jane's parents] and the way they did what they did to you at the instance with regard to the wedding and that (Jane laughs nervously). I mean, that was bad enough, you getting married in a church and getting married in white, and getting married again and everything else like that. But to actually come up with something like this (Jane

laughs), it would be just like the Mayor of Hiroshima, who said, "What the hell was that?"... I mean to say, if they excommunicate us, or whatever, we've got an excommunication from our family.

Jane: Cut out of the will.

Steve drew on metaphors related to major social disasters to express his concerns about the possible repercussions of telling Jane's parents or friends about their children's donor conception. In some part, his position appeared to reflect his Catholic upbringing and experience of estrangement both within his family (he was divorced from his first wife and is estranged from his children from that marriage), and fears of further rejection from Jane's family. When I asked Steve if he thought there was a stigma attached to having children by DI, he said:

Steve: I just feel that it can be, a thing that's there, it's an underlying thing, nobody really knows. You don't know, it's an unknown territory. Whether there would be a stigmatism (sic) placed upon it, we have not found any among those that know about it.

Jane: It surprised Steve that I just blurted it out. "Did you really?" he'd say. "Yes!" [she said] Eh, dear?

Steve: Yeah, it's a sort of thing that some people may react to adversely [and think it was] the wrong thing to do, and you know exactly that some people around have got that opinion, and it's out there in the community.

Steve's comments illustrate Goffman's (1963:14) contention that there arises in those who are stigmatised a sense of not knowing what others "really" think about them. Steve's fears of social reprisal do not appear entirely justified because Jane said that the friends she had told had all been supportive. She had told Steve's sister, a former maternity nurse, who had been supportive and helped look after the twins when they first came home after their birth. Moreover, because Steve had had children biologically related to him in his first marriage, and his current infertility arose from a failed vasectomy reversal, he did not consider it an "issue" in the way that other men did. Steve appeared to justify his desire for secrecy on the basis that he needed to protect his children from the social slur of being 'different'. He said:

Steve: The main thing is the impact upon those two children down there [he points to the children playing in the room]...is the important thing that I've, or we consider, is the effect, or what's the effect. I mean to say, I can be mercenary about things. I, you know, that's why Jane says to me I've been too cold-hearted about the whole thing.

Although Steve invoked an argument about the need to protect his children from harm by keeping their DI origins a secret from others, he also may have been concerned about protecting his *own* interests in perpetuating the belief that the children were his biological offspring. Other researchers have found that when social fathers of children conceived by DI invoked an argument about the need to protect their children, their primary agenda was to protect themselves (Snowden, Mitchell and Snowden 1983). Andrew, for example, argued that by not telling others of his daughters' DI origins, he was protecting them from being labelled 'science kids' or 'test-tube babies'. Annie, however, challenged his motives for invoking this particular argument, and claimed that his underlying motive was to protect himself. She said:

Annie: And then I've accused Andrew of using this for his own ends, to prevent him from telling people, haven't I? I've accused you of actually using this idea to stop you from facing up to the fact that you should tell your mother.

Andrew: Yes, that's probably correct, yes.

Annie: And I wonder if actually Andrew's reasoning for putting the girls first is a little bit of protection for himself.

Andrew: Well, obviously it is. I won't deny that.

Annie: Well, you said it wasn't.

Andrew: With the realisation that, one day, the fat lady sings, you know.

Andrew appeared to recognise that one day he would have to tell his mother because he had come to the conclusion that to be 'fair' to his daughters, he would have to tell them about their DI origins.<sup>6</sup>

Jane's ambivalence about telling her parents was embedded in her relationship with them:

Jane: I think I might have told my parents, but the thing is, we actually lost ties with them about the time, about six months before we got married, I think. They decided not to tell us that they wouldn't come to our wedding. But they actually sent back the thing to say that they're not coming to our wedding, because I was getting married again, and I got married in a church, and I got married in white, so, my father was quite against it...

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<sup>6</sup> See Chapter Nine for a discussion of Andrew's plans to tell his children about their DI conception, and to then be more 'open' with others.

I was hoping, when you [the interviewer] were coming last time,<sup>7</sup> I would sort of talk to them, but my father's having lots of problems with his health, and I don't want to add to the stress. I was hoping to talk to them, but I would go past where we got married and there's like a still silence in the car, and I think well, hey, you know. I haven't really accepted how they treated me... I'd like to tell them, but it's just getting worse and worse... it seems to get longer and longer, and it gets... every time I want to talk about it, there's sort of like... I know that Steve gets quite stressed about it and so do I really.

But, you know, it just makes it really difficult. My brother doesn't know, and my sister does. Um, a few friends know, but I do find that side of it really difficult, I really find it really hard. Sort of like a barrier, I suppose.

Much of Jane's ambivalence about telling her parents seemed to be attributable to fears about how they might react, which were reinforced by Steve's concerns about the risks of telling. Steve's sense of risk was significant.

Steve: It's like knowing there's a minefield there, and you have to be able to cross it without anything going off. It's an area where you know there's the hidden dangers, the chances are that you'll have acceptance or you'll have rejection.

Steve pointed out that perhaps there is always a risk in sharing secrets. Jane was still considering the costs and benefits of taking such a risk. On one hand, she wanted to bridge the gap between her and her parents by telling them an intimate detail about her children's genetic origins. On the other hand, Jane thought that they had rejected her in the past and might do so again. She was also concerned about the possible repercussions for her parents. At the same time, maintaining the secret appeared to be increasingly burdensome for Jane, particularly because she perceived it as a barrier to intimacy with others. She raised a point about the longer a secret is kept, the harder it is to tell and, presumably, the more work is required to keep the secret from being revealed.

The conflicts over secrecy and disclosure experienced by Andrew and Annie and Steve and Jane reveal some of the dangers of secrecy. Bok (1984) suggests that while some capacity for keeping secrets and choosing when to reveal them is essential, keeping secrets can also harm and debilitate. She contends that shutting out criticism or feedback from others may lead to people becoming "mired down in stereotyped, unexamined, often erroneous beliefs and ways of thinking", or may "lower resistance

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<sup>7</sup> Our initial interview was to take place during Jane's parents' visit. Although she had planned to use the impending interview as an opportunity to tell her parents about the twins' DI conception, she had been unable to do so. The interview was subsequently rescheduled for after her parents' departure.

to the irrational and the pathological” (Bok, 1984:25). As Bok suggests, because secrecy can impair judgement and choice, and become obsessive, it can negatively affect others, even when this is not intended.

**“It’s not a secret. It’s just something they don’t know”**

For many parents of children conceived through DI, the issue is not so much to do with secrecy as it is about privacy and confidentiality. Writers often distinguish between secrecy and privacy (see Warren and Laslett, 1977; Tefft, 1980; Bok, 1984). Some have defined secrecy as involving obligatory concealment, and privacy as involving voluntary concealment (Tefft, 1980:13). Warren and Laslett (1977:44) claim that privacy and secrecy can be differentiated by the moral dimension of the behaviours to which they refer. They argue that secrecy implies the concealment of something that is illegitimate, or negatively valued. Thus, according to Tefft (1980:14), stigmatised persons keep secrets to protect themselves from economic, legal or social punishments. In comparison, privacy can be seen as something that protects behaviour that is generally regarded as legitimate, morally neutral or valued (such as consensual marital relations) (Warren and Laslett, 1977:44).

Writing about the sociological significance of the secret, Simmel (1950:331) contends that secrets are “the sociological expression of moral badness”. Simmel (1950:334-335) also suggests that secrecy has a dual role in that “social conditions of strong personal differentiation permit and require secrecy in a high degree; and, conversely, the secret embodies and intensifies such differentiation”. In her review of the literature on family secrets, Brown-Smith (1998:25) argues that this definition tends to emphasise the negativity of secrecy. Her more neutral definition, in relation to family secrets, is that “a family secret is any information that directly affects or concerns one but is either withheld or differentially shared between or among family members” (Brown-Smith, 1998:23).

Different meanings have also been applied to the concept of privacy. Margulis (1977:10) suggests that privacy represents the control of transactions between persons with the aim of enhancing autonomy and/or minimising vulnerability. Laufer and Wolfe (1977) argue that privacy relates to the preservation of personal dignity through the management of information and interaction. They also suggest that privacy

relates to the life cycle: at various developmental stages in life (e.g. becoming an adult or a parent) patterns of privacy change. Thus, privacy is often conceived of as a dynamic, relational concept involving the management of self-other boundaries (Derlega and Chaikin, 1977; Foddy and Finighan, 1980). Similarly, Bok (1984:11) defines privacy as limiting physical access to one's 'personal space' or to information about personal matters. According to Bok (1984), secrecy and privacy overlap, particularly in the private lives of individuals where secrecy guards against unwanted access by others to information central to personal identity. Given the private and personal aspects of reproduction and its association, particularly for men, with sexuality and virility, it is clear that secrecy and privacy may overlap considerably. As exemplified in the cases of Annie and Andrew and Steve and Jane, this overlap might become a source of conflict between partners. For example, one might consider secrecy unnecessary and inappropriate among close family and friends and might associate the withholding of information in this context with negative constructs of lying, deceit and dishonesty, rather than the more positive meanings associated with privacy and confidentiality.

That decisions about secrecy and disclosure are related to the meanings people attach to 'secrecy' is illustrated by a recent study on the disclosure decision amongst parents of children conceived by DI (Nachtigall et al, 1998).<sup>8</sup> This study revealed that disclosers used the term 'secrecy' in a negative psychologic sense and made reference to the harm to family relationships incurred by keeping "family secrets" (Nachtigall et al, 1998:1166). In contrast, non-disclosers derived their stance from the principle of confidentiality and discourses about the right to privacy and freedom from unwanted intrusion. Illustrating the latter stance, and also the way in which secrecy and privacy overlap (Bok, 1984), Paul and Fiona considered that their decision to have a child by DI was personal, and they did not initially tell any family or friends about it. When asked why, they said:

Fiona: I didn't really want to talk about it, because, I mean, at that time I don't think it was sort of known a lot about it. You know, it was sort of new and that. Whereas IVF was more... that

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<sup>8</sup> This study, carried out in the United States by Nachtigall et al (1998), explores patterns of disclosure and non-disclosure among couples with children conceived by DI, particularly in relation to informing their child of their DI conception. When asked if they had told, or planned to tell, their children about their DI conception, 54% of the sample were categorised as 'nondisclosers', 30% as 'disclosers' and 16% as 'undecided'.

was always on the radio, and those kind of things and in the magazines there's a lot about that...but not about donor.

Paul: Did you ever think that if you said anything you might finish up having to defend what you'd done?

Fiona: Yeah, in some ways, yeah.

KH: Do you think people might judge you in some way?

Fiona: I don't think our real friends...like Trudy and Neville would, would they?

Paul: Well, I don't...you know, my attitude is more...it's not an issue, so once you start saying these things you run the risk of um, this is a big issue sort of thing, and you're almost inviting comment, or you know, this question of having to get into a philosophical argument, when you don't want to get involved in it. It's just, why do I have to defend myself over this, sort of thing, of what's happening?

Fiona: And it was between Paul and I that made the decision...

On some level, Paul and Fiona felt that DI was not socially acceptable. As a result, they felt most comfortable keeping their decision to have a child by DI to themselves. They may also have felt less of an emotional need to disclose to others because they already had one son who was biologically related to both of them, but had been unable to conceive a second child (and “complete” their family) because of Paul’s lower sperm count. Paul also believed strongly that his daughter, Elise should be the first to know about her DI conception, chiefly because of his experience as a young man of finding out that his ‘uncle’ was, in fact, his cousin. He recalled:

Paul: Mum said to me out of the blue one day...I'm not sure how old I was, but probably, maybe sort of early teens...said my uncle wasn't really my uncle, but was my aunty's son born out of wedlock. And here's this person I'd been, you know, was my mother's brother...I thought was always my mother's brother, was not really. It was almost...it was a cousin to me and ah, while it never affected me much, it just seems such a surprise...I said, “Why did I have to know this way?” sort of thing.

He was told when he was 21, at a party away from home, by someone who had nothing to do with the family or something. And from then on he was um...it really screwed him up. And that sort of played on my mind, and so for me there was that issue. And the other issue for me was that Elise had to be the first one to know.

Paul thought that the ‘accidental’ revelation by an outsider to his uncle/cousin had ruined this man’s life, and he therefore wished to avoid his daughter having the same experience.<sup>9</sup> Thus, unlike Steve, who was primarily concerned about others’

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<sup>9</sup> Curran (1997:26) reports a similar situation in which an Irish immigrant to the United States discovered from his birth certificate, when attempting to take out US citizenship, that his ‘aunt’ was in fact his ‘mother’. As a result, he embarked on a career of alcoholism that finally killed him. According to old family letters, it was the family lie that destroyed him, not the illegitimacy – his loss of trust in his family coincided with his alcoholism.



reactions to his conceiving a child by DI, for Paul, protecting his child from harm was a paramount concern. Paul wanted his daughter to be told at a time that he determined, and their power to control the flow of information would be potentially undermined by telling others.<sup>10</sup>

The reasons other parents gave for non-disclosure were often similarly complex, and related to experience of family relationships, geographical proximity to significant others, and a variety of contingencies. Mike and Caroline also chose not to disclose to others while they were having DI treatment. Caroline said:

Caroline: [I decided] I would play it by ear. It wasn't as if I wanted to keep it a great big secret, but then I didn't feel the need to go out and rush and tell everyone. It was our personal business, and still to this day, there's a lot of our very good friends who don't know...it was something that I thought I would deal with in the future. I didn't make a decision either way, right there and then. I didn't think to myself, "I'm never going to tell this child." It was something that I thought I would play it as to how I felt about the situation, because it was still new.

Caroline's comments illustrate Bok's contention that secrecy about one's plans is necessary "not only to protect their formulation but also to develop them, perhaps to change them, at times to execute them, even to give them up" (1984:23). Like other couples who are attempting to conceive, at the early stages of DI treatment, Caroline did not know how their plans would unfold: whether she would get pregnant, the outcome of the pregnancy and so on, so it was important to keep their plans to themselves.

Mike contended that they did not have the time to tell anyone because, just as they started DI treatment, they moved to a new city where they knew no one. The couple said that the private and personal nature of infertility and fertility treatment did not make good dinner-party conversation, nor was it something one raised over the phone talking with geographically-distant kin. Caroline's sister, Mandy, was the first person they told about their daughter's DI conception. Caroline recalled the occasion:

Caroline: I had brought Toni down when she was about eight weeks old from the North Island, down to meet the family basically and my sister was going through a rough patch at the time. Life's

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<sup>10</sup> To control the flow of information to others about their DI conception, Paul first told their daughter Elise of her DI origins when she was five years old. He and Fiona then informed their older son of her origins and then their parents. They were unsure if other family members knew, or whom Elise might have told. Their strategy worked for them, in that Elise's DI origins has not become an "issue".

pretty tough, gee...she'd had one child and her second baby had just been born and her husband had lost his job. And I said, "Oh well, look, you know, you've got a nice healthy baby, and da da da," and then I just sort of... it was the right time to tell her, so I told her. And she was just amazed. She couldn't believe that we could have gone through that and not told anyone. And she said, "Why didn't you tell us?" And I said, "Well I don't know." It wasn't that we were... we certainly weren't ashamed of it or anything like that.

Caroline did not disclose to her mother until after their second daughter, Lucy, was born, three and a half years after beginning treatment. Initially, she attributed not telling her mother to the physical distance between them, but later, she acknowledged that other factors in her relationship with her mother might account for her delayed disclosure. By the time she told her mother, Caroline decided she could tell because she no longer cared what her mother thought.

Caroline: I think I might know now why I left it so late. Because I remember my mother making a comment once about somebody who'd had... it might have been donor insemination or surrogacy...and sort of scoffing at it. Because here was she who'd had seven babies, plomp, plomp plomp, just like that, you know, and obviously thought... Not that I ever thought for one minute that they'd disown the children. I never thought that. But it was just I knew all the questions that were going to be asked, and I just couldn't be bothered I suppose when Toni was a new born baby, going through all those questions... the whys, the what ifs and all the rest. Whereas, when I told my sister, I knew that she wasn't going to ask silly questions. I suppose I didn't trust my mother enough to think that she would ask the right questions.

As in Jane's case, the issue of 'trust' was related to how Caroline's mother might react, rather than whom she might tell. In neither case was trust about keeping the secret. Although she did not expect her mother to reject the children, Caroline did not trust her *not* to question her decision to have DI or to judge her in some way.

Caroline: My mother had seven children so easily and here was us who had to have help with one and as it was she ended up being a caesarean (she laughs). I didn't feel like a failure, but I often thought my Mum would have thought, "What's wrong with these girls nowadays? Can't they just have babies normally?" (she laughs).

Caroline was concerned that others might perceive their conception and birth as not 'normal' and it threatened her competence as a woman. Although she had not trusted her mother enough to tell her initially, the question arises why she did not tell her sister, with whom she was "close".

Caroline: My sister was surprised. Probably more from the fact that we had gone through the whole pregnancy and had Toni before we had actually even told her. I think she thought she probably deserved to know before then, and she probably did because we're quite close. At the time it was really personal just to us, and we just wanted to get through it, I suppose. Comes back to the thought of having frozen sperm. Okay, you can achieve a pregnancy but can you hold it? So you wanted to make sure, and then you wanted to make sure that the

baby was going to be fine, and that all fingers and toes would be there, and that sort of thing. And once that initial worry is over, then it was easier.

Although Caroline had eventually found the “right time” to disclose to close family members, Mike had not found the “right time” to tell his family members. He said:

Mike: I have not made a decision not to tell my sisters. I have not found a time suitable to do it. I'm certainly not going to talk about it when we're all together. I'm wary as to which one I'd tell first, because of the way that we'd be...

Caroline: Construed.

Mike: So, if and as and when they show some interest or we get closer and we have more time together, then they will be told. I'm not concerned about that. The longer it goes I guess, the possibility is that it'll be harder to do, and I might question the need to tell, but it's not a secret, it's just something they don't know.

Mike's recognition that the longer he kept the information a secret from his family members, the less likely he would ever tell, highlights the issue of the difficulty of shifting from a position of non-disclosure to one of disclosure when the information has been withheld for a long time. Because disclosure about personal matters often takes place in the context of intimate relationships, withholding information may raise a question about the level of trust or intimacy that exists between people.

Illustrating the point made above, Mary said that she had not told a close friend about her children's DI origins. The friend had commented that her children did not resemble her and her husband and now she felt it was too late to do so.

Mary: I've never told this other friend of mine Barbara, even though we're very close. And I sort of don't feel as if I should tell her now.

Brendan: They have asked... “Jason's not like you”...They have asked, well not asked, but sort of queried, commented that, you know...

Mary: Jason's not like us...and I think I've left it too late. I just feel that if I tell her now, she'll be upset that I've never told her before, and yet I never really told her because I didn't tell another friend because her husband was a real gossip and I just couldn't tell her because I was scared that he'd go around and gossip and tell the whole world, you know. So, it is a bit hard sometimes.

Mary's experience reveals how decisions about secrecy and disclosure are made not just on the level of one-to-one relations, but in the context of the web of social relations in which people are embedded. The essential element here is trust and, in particular, trust in people who are some distance removed.

Several couples commented that they would tell about their child's means of conception only if they believed a person "needed to know". This decision was often made in relation to whether anything could be 'gained' in terms of support or approval for the decision to have a child by DI. In these situations, couples would opt for non-disclosure if they believed that a person's values, morals or worldview would preclude them from accepting it or being supportive. Caroline and Mike used this premise to justify not telling the priest who baptised their daughters about their donor conception. Caroline said:

Caroline: When we got them baptised, I felt that perhaps I should have told the priest, but then I couldn't.

Mike: Well you put them on the spot because their policy is "Thou shalt not..." They're not supposed to do it.

Caroline: I did feel a little odd about that. Well, I...

Mike: Our priest, the one who married us...

Caroline: He'd have been all right. And Father Matthew, he would have been fine.

Mike: One of the military padres, he's no problem. And he also knew my sisters, but I wouldn't take the chance on a person who I don't know that well. So, why expose them to something when there is no advantage that can be gained?

Caroline: Well, I suppose that's what I thought in the end. He probably doesn't need to know, and I suppose I thought well, you know, if there is a God up there, he would understand why we did it, and the reasons for it, and hey, I'll bring these children up to be good children.

Mike and Caroline's decision had more to do with the type of relationship they had with the particular priest rather than because of his position. If they knew the priest well, and trusted him to understand their position, they might well have chosen to tell him. By telling him they risked being told the church's 'official line' that condemns DI as immoral (Lauritzen, 1993:90-91).

Kathy, mother of a daughter conceived by DI, chose not to disclose her daughter's origins to her English grandmother, for reasons similar to Caroline and Mike's. She said:

Kathy: I'd heard her views over the years on other members of the family that had had children out of wedlock. And she was quite a strict upper class old English lady, and when you get the aristocratic type, they've got very fixed views, and she wouldn't have approved of my doing it

by choice, I would think. Yeah, and that mattered. Not so much that it mattered as such, but I thought, well what would be gained from telling her? There would be no support or goodwill gained on behalf of Melissa. There would be no support for me gained by telling her this. If anything it would... nowadays I would probably look at what would be gained by saying something.

Like Kathy, Alice and Peter, who had told most of their close family members about their daughter's donor origins, decided not to tell certain of their relatives whom they regarded as holding "bigoted" views. They said:

Alice: Auntie Joyce is very strong-minded and quite bigoted at times, about all sorts of things, and it's just...

Peter: And it would be a mistake to tell her. Not so much, I mean we've never really been...we've never wanted to keep the information from people, except we've come to realise that kind of the ultimate test is whether or not it could ultimately be hurtful to Erica in some way. So, we'd really only tell people who're likely to treat the information in the appropriate way.

Like Paul, when deciding whom to tell and not to tell, Peter revealed that protecting their child was the paramount consideration. This, in turn, supports the contention that a reason often given for keeping DI a secret is to protect the child from possible harm (Daniels and Taylor, 1993:157).<sup>11</sup> Kathy's and Peter and Alice's experiences also illustrate that non-disclosure is a tool for managing identity.

### **Privacy as a means of impression management**

Non-disclosure is significantly about managing self-other boundaries and about managing self-identity which, as previously stated, connect to the concept of privacy (Foddy and Finighan, 1980). These authors contend that:

Privacy is the possession by an individual of control over information that would interfere with the acceptance of his [sic] claims for an identity within a specified role relationship (Foddy and Finighan, 1980:6).

Foddy and Finighan argue that privacy is a dynamic process which "does not seem to be important in situations when people feel completely at ease with their relationships with others and where the others' standards are the same as their own" (1980:9-10). However, in situations where standards clearly or potentially differ, the individual attempts to manage his/her identity, or the definition of self that he/she seeks to

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<sup>11</sup> It should be noted, however, that in these cases the parents do not intend keeping the secret from the child him/herself. Thus, they are not seeking to protect the child from knowledge of their DI origins, rather to protect them from other people's possible reactions to this information.

project or publicly claim (Foddy and Finighan, 1980:3). This relates to Goffman's work on stigma and the management of a "spoiled identity" (1963). Foddy and Finighan (1980) acknowledge the significance of Goffman's work in the area of privacy and impression management. They also cite Weinstein and Deutschberger's argument that individuals give off 'impressions' aimed at influencing the other's perception of the situation and the individual's identity (1980:3). In this way, the individual seeks to control the alternatives the other will have when identifying him.

Several couples talked about non-disclosure as a way of managing their public 'face' in two particular semi-public contexts: the antenatal group, and the workplace. The former social context was more often raised by women, and the second by men. Alice, the mother of a daughter conceived by DI, had not wanted to disclose to the antenatal group about her infertility problems or about her daughter's DI conception. She said:

Alice: [I feel 'different'] in one context and that's when we meet with our antenatal classes that we went through with Erica when she was born. Almost all of those women...there are only two of us who are not onto the second child already...have had the second child or are about to. ...We never disclosed to that group about Erica being different and she very much, you know, I do feel the difference a bit there. I haven't been able to be open about our fertility problems, because I didn't want to have to disclose the history of it to them so far.

Alice did not feel comfortable disclosing within a group situation where she might be considered 'different'.<sup>12</sup> Alice and Peter compared their struggle to achieve a pregnancy and the birth of a child with the apparent ease with which others in the group appeared to have had children.

Peter: It was a bit hard anyway, because half of them are rabbits (he laughs).

Alice: Breeding like rabbits (we all laugh).

Peter: That's shocking [he says ironically]... they were young and kind of fertile couples weren't they? Whereas we're not (he laughs).

Alice: Every meeting there'd sort of...

Peter: There'd be another one.

Alice: ... be comments about who's pregnant now, and da da da, you know. It's been quite a big sort of issue. They've stopped asking me which is quite good (she laughs). I probably will tell

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<sup>12</sup> Self-perception of being 'different' and the perception of others of difference are discussed in more detail in Chapter Eleven.

them that we have fertility problems. But I don't know if I'll tell them about the DI. I'm not sure about that. We don't have that kind of closeness of relationship.

Peter's unflattering remark about others in the antenatal group "breeding like rabbits" reveals the ambivalence 'infertile' people often feel about those who appear to reproduce with ease. Alice and Peter's age and their inability to conceive so effortlessly set them apart from others in the antenatal group making it more difficult for them to disclose about their infertility problems and DI conception. Non-disclosure in this context was also related to the fact they did not feel they were among sympathetic others who shared the stigma of male infertility (Goffman, 1963:20).

Further illustrating that non-disclosure is a form of stigma management, Sandra said that she would not tell others in the Multiple Birth Club that her triplets were conceived by DI. She said:

Sandra: One of the multiple birth mums knows that I was at the infertility clinic, but she doesn't think that our kids are natural kids because we had to go through the infertility clinic, whereas her children were naturally conceived, so therefore they're definitely her children. And therefore in that kind of a situation I feel there is no point at all in saying the rest of it. I guess that we do prejudge people's attitudes and that may be wrong, but generally, if I felt that there was going to be bad vibes about the person being told, I wouldn't tell them. If I felt that somebody was going to be very uncomfortable with me telling them, then I wouldn't tell them, but it's not because I want to hide something, it's only because I think that they would not respond well to it.

Sandra's reasons for non-disclosure link to Shenfield's contention that anonymous sperm donation protects privacy because it enables recipient couples to keep the "artificial" means of conception of their child a secret if they so wish (1997:372). It also highlights that thinking about children's means of conception in these binary terms contributes to the perpetuation of differentiation (Simmel, 1950:334), prejudice, and public ignorance about the many forms of assisted conception.

Several fathers of children conceived by DI commented that it was difficult to raise the subjects of infertility or DI in their respective workplaces. Neil commented:

Neil: I mentioned to my boss that I was going over to Adelaide and what it was for - FSA (a conference of the Fertility Society of Australia). He was a bit uncomfortable with the subject I thought, which was interesting.

Because his boss seemed uncomfortable when Neil raised the issue of infertility, he would be unlikely to disclose to him that he had children through DI. Similarly, others had found that alluding to difficulties having children was a conversation “stopper”. Diane said:

Diane: [People] almost get embarrassed don't they when people mention things like that. It's like when people say to you, "Well, when are you going to have some more children?" and I say to them, "Oh, I've had a couple of miscarriages," and they immediately shut up (she laughs). That's people you don't know very well. "When are you going to have children?" (she laughs).

While Diane suggested that topics such as infertility might be met with silence, some men commented that they would not disclose to others at work about their infertility or having children conceived by DI because they might become the butt of jokes. This highlights the difference between people's reactions to female infertility and male infertility. Peter opted for non-disclosure as a way of protecting his reputation, illustrating Foddy and Finighan's contention that a certain level of ignorance is often necessary in certain social situations because information about identity in one situation can interfere with the maintenance of an identity in another situation (1980:9).

Peter: There were people at my work, who I would have liked to have told, but I didn't think would be... would consider the information sort of... or use it appropriately. Just always be a little bit concerned that they'd think less of me, or...

Alice: The sort of people who joke about... sort of... make jokes about manliness, and you know...

Peter: You know just workplace humour really, you know... pretty innocent, but just didn't really want to be kind of... the butt of jokes. So, not that I think they would have done it deliberately. It would have been pretty innocent because they had reasonable regard for me, but even so, you know, I just didn't feel comfortable telling them.

Peter's concerns that work colleagues might think 'less' of him if he told them about his infertility illustrate the way that notions of male fertility, virility and sexuality are so strongly intertwined in our culture (Rowland, 1985; Miall, 1986; Baran and Pannor, 1989:25). In this circumstance, non-disclosure operates as a form of self-protection in terms of avoiding disruption or damage to a workplace identity.

Peter's mother-in-law, Janine, also aware about the stigma of male infertility, had made the decision not to tell her husband. She said:



Janine: I have never discussed this with my husband, because he's Alice's step-father. And he has real macho feelings about things. And I just feel that if he knew, that he would think less of Peter. And I don't want to...so I just never...he knows...I think he thinks that it's an IVF baby... that she's IVF, but he doesn't know that it's donor sperm.

Janine's decision raises the issue of the relative social acceptability of IVF and the possible inacceptability of having to use donor sperm, because of the stigma attached to male infertility, and the negative connotations of DI which have kept it a public secret for so long. Like Sandra's experience in the Multiple Birth Club, it also illustrates the way in which secrecy, which is most likely to be deployed in circumstances of social differentiation, also serves to intensify such differentiation by limiting public knowledge and potential acceptance of it (Simmel, 1950:334-335).

Other participants in this research commented that, if they disclosed to others about their experience of assisted conception, they intimated that it was IVF rather than DI. Joanne, grandmother of Richard and Belinda's daughter Madison, said:

Joanne: I do actually find I don't actually say to people that it's a donor. I actually say it's an IVF [baby] and people sort of know this word, and whether it's through ignorance of not knowing what it is, but they just leave it at that. And Belinda actually said to me when I was selling [cosmetics], a few people had sort of said, oh they'd had a few problems, and Belinda said, "Just say to them it's IVF Mum, and then they think they know, or they don't wish to ask any more questions." And it just seems to work like that. It's just one of those subjects, you tell them something and so they leave it.

This scenario indicated that while IVF and 'test-tube' babies were publicly visible and positively associated with the 'miracles' of modern medicine, DI was less well known and negatively associated with male infertility, and the use of sperm from an unknown third party. Joanne's comments revealed that there is a fine line between arguing on the basis of what is known and understood, and protecting against the potential stigma of male infertility.

Some couples spoke of the difficulty of controlling who knew about their fertility treatment. Diane and Chris travelled a long distance for fertility treatment, which involved taking time off work, so it was difficult to keep it a secret. However, they had some control about *what* people knew. They said:

Diane: Like my work mates don't know, for example. Your [Chris's] work mates don't know do they?

Chris: No. They know we go to Auckland, but they just think we're going for IVF. It's quite a convenient little...yeah...because you can't hide it, because there's so much emotional stuff that goes with it. You're always away...so...yeah....

KH: Would you not tell people at work because it feels uncomfortable, or because you just don't have those sort of relationships?

Chris: No. I mean it's not...yeah...it's just not their business. I mean it's not a secret.

KH: It's not appropriate?

Chris: Yeah. It's not for open broadcast. It's just the way it is.

The couple did not frame their non-disclosure at work as a form of secrecy; it simply was not their colleagues' business. Like other parents mentioned in this chapter who did not share information that they thought was not other people's 'business', non-disclosure was used as a tool to protect their privacy.

Like Chris, several couples said that they did not wish to "broadcast" information about their child's origins. For parents like Sean and Pippa, this was a way of protecting their vulnerable child from the possibility of social stigma.

Sean: We don't want to tell the whole world.

Pippa: No, not yet anyway. As Elspeth grows up, probably more people will find out about it, because it's something that she might mention, directly or indirectly. And that's something that we'll deal with.

KH: But at the moment its close family and friends?

Pippa: Yes. People that matter in our lives. Not just anyone. We don't want her feeling different. I think that's quite important because I think people treat you differently if they know you're different. And I don't want her known as the donor baby. I want her known as Sean's baby, our baby.

Pippa emphasised that she wanted her daughter's identity firmly established as *their* daughter – not as a child who might be labelled as a "donor baby" and therefore seen as not entirely *theirs*. After all, the term "donor baby" implies that a *baby* was "given by someone else". At the same time, Pippa acknowledged that more people might know about it in the future if their daughter chose to tell others. This suggested that having told their daughter they had a sense that they would lose some control over the flow of information about her conception, but that would be less of a concern when their daughter was older, with a more established social persona.

### Secrecy as an adaptive process

Some couples claimed to have changed their views on secrecy and disclosure over time, illustrating that secrecy is part of an adaptive process. Many couples had begun by wanting to keep their experience of DI and their child's donor origins a secret but, once their children were born and because of other contingencies and circumstances in their lives, they had become more 'open' about it, both with their child and with others. This implied that secrets have a particular 'life'; they may be concealed for a period of time and later revealed for a variety of reasons.

Initially, when embarking on DI treatment, Sean and Pippa had thought about keeping the whole experience a secret to avoid the contingent difficulties of opening Pandora's box (Bok, 1984). They said:

Pippa: [Keeping it a secret] did cross my mind, I have to admit. It probably crossed Sean's mind.

Sean: Yes, it did.

Pippa: Initially, just 'let's not tell anyone, and nobody will ever know'.

Sean: But you can't get away with it.

Pippa: I think it would fester, and you might inadvertently say something, or she says something, or something could go wrong. And you could ruin your relationships.

Sean: Yes. It's too big a risk.

Assessing secrecy as "too big a risk" draws on public narratives about adopted children or young adults inadvertently finding out that one or more of their parents was not, in fact, their biological parent, and the frequently negative consequences for them *and* their families that ensue (Curran, 1997). This relates to Paul's experience discussed earlier in this chapter, which also indicated that stories about the serious psychological repercussions for adopted people and their families of sudden revelation about parentage play a significant part in decisions many couples make about disclosure. The idea that personal relationships are put at risk by keeping secrets contrasts with the stance of those, like Steve, who chose to keep DI a secret because they believed that revelation entailed too many risks. Secrecy is, therefore, a form of risk management. The difficulties confronted by people like Andrew and Annie and Steve and Jane when trying to keep their secret, however, highlights that it is difficult to maintain secrets within intimate circles because of the temptation of

revelation (Simmel, 1950). Simmel argues, moreover, that secrets should not be necessary in that context because this type of social formation usually levels its members (1950:335).

Like Pippa and Sean, Allan and Sandra had initially thought that they would be secretive about having DI.

Allan: And at that stage I think I wanted to be secretive about it. I don't know that Sandra was.

Sandra: Well, I was happy to go along with whatever you wanted.

Allan: And I don't think the clinic was very happy with that attitude.

Sandra: And they gave us a book and things to read on it as well. So, yeah, they were keen for us to be quite open, but at that point we weren't ready for that, were we?

Allan: We had a difficulty also...or I had a difficulty, in that my ex-wife was still alive, and not always saying complimentary things [about] me to Jacqui and Tom, our older children. So, I thought, well, rather than make other ammunition there, I'd prefer that she didn't know, but of course that would mean that Jacqui and Tom didn't know. And then I think I also, to be honest, had a hang-up about, you know, thinking that I could pretend that they were mine and that sort of thing, from a genetic point of view. Initially, and probably until they were born. And then we talked about it more. As time went on we made the decision to be open about it.

This scenario illustrates that secrecy and disclosure are embedded in particular sets of relations which shift and change over time. Allan and Sandra's situation illustrates that secrecy is used as an adaptive strategy. Sandra supported Allan's initial desire for secrecy. As time went on, however, it became apparent to Allan that keeping the information a secret meant that he was not being open and honest with his grown children. By the time the triplets were two and half years old, Allan decided to tell his older children about their DI conception. By this time, his former wife had moved overseas, so Allan felt that there was "less damage to be wrought". He and Sandra also thought that Jacqui and Tom had already developed a bond with the triplets and that hearing about their 'different' means of conception would not alter that. Allan also felt that he had an obligation to tell his older children: it was their business, too, because from being one of two children in a family, each was now one of five, which would have implications for their inheritance.

Some parents raised the issue of the difficulty of telling some people and not others. Peter said that when considering telling one person, he had had to consider their entire

social network because to tell someone, but ask them to keep the secret, might be an imposition. This raised the issue of the burden on the secret-holder.

Peter: And it becomes...it's not just...you can't just decide not to tell one person. Often it's groups of people, and it's quite difficult to tell one person and expect them to...um...and it's not really fair to tell them because then they've got to kind of keep a secret. And, it's actually easier, and probably fairer on people if you're a bit more even-handed than that.

Selective telling within close social circles also raises the spectre of the information being 'leaked' unintentionally or otherwise to those who have not been chosen to be privy to the information, a prospect that could create another set of problems.

Kathy and Joel's experience illustrated the difficulties of telling some people and not others. They had initially only told people at the Infertility Society about their daughter's DI conception. But, as a young baby, Melissa was suddenly taken ill and needed a transfusion of compatible blood that neither she nor Joel could provide. Kathy recalled their situation:

Kathy: We decided really to say nothing at all. We were comfortable with what we were doing. The thing that occurred to me at the time was that some of the people in the Infertility Society knew. We had told them. But to me, if you're telling some people you've got to tell everybody because it's such a small world. As I say, there we were stuck in a hospital and they were seeking information off us and the pair of us were like stunned mullets looking at one another thinking, get my mother out of the room. They must have wondered what an earth was happening in this hospital, because Joel and I both looked at each other at the time and thought, well, what are we going to do with this? We made a decision at that point, we discussed it and we were out in Australia and we wrote a letter and photocopied it and sent it to everybody.

Kathy's and Joel's precipitous decision to disclose to "everybody" was in response to a particular event, their daughter's sudden illness, and Kathy's belief that if you tell someone, you have to tell everyone because, having told someone, you no longer have any control over the flow of information. Implicit in this is the assumption that information flows freely through social networks, and so it might as well come from the primary source. This raises issues of identity and control (White, 1992). When their daughter's life was in danger, Kathy and Joel's identities as parents became threatened. They lost agency and had no choice but to disclose information about their daughter's DI conception to the doctors. Thus, through seeking to control their identities as parents and securing their daughter's life, they lost control of the flow of information about her conception. Kathy's later comment that now she would only

tell others if something would be gained by doing so, raised the question of whether she later regretted their decision to tell everyone they knew. This regret may be linked to the subsequent loss of power as a result of losing control over the flow of information (Bok, 1984:19) and, perhaps, to their changed identity. It also highlights Bok's (1984:20) contention that control over secrecy provides a safety valve for individuals in the midst of communal life. She asserts:

To restrain some secrets and to allow others freer play; to keep some hidden and to let others be known; to offer knowledge to some but not to all comers; to give and receive confidences and to guess at far more: these efforts at control permeate all human contact. Those who lose control over these relations cannot flourish in either the personal or the shared world (Bok, 1984:20).

Other parents who, like Kathy, had at one time made a 'blanket' decision to tell "everybody" about their child's donor conception, also said they later changed their position and would now be more discreet, only telling those who "needed to know". Neil and Patricia had decided to be "relatively open" about having fertility treatment. When their first daughter was born, they thanked the fertility clinic in the birth notice in the newspaper. They maintained that it was the first time that the fertility clinic had been acknowledged in this public space. Since then, as part of an Infertility Awareness Week, they had agreed to publish their story in a national magazine, using their own names in the article, thus effectively telling "the whole country" about their DI conception. According to Patricia, this degree of 'openness' was prompted not only by the political motivation to raise the profile of infertility nationally, but also a number of other factors.

Patricia: My motivation to do that was two situations really: one where my father was perhaps discussing it amongst family as though it was some skeleton in the closet sort of thing, and the reaction of the relatives really. And I just sort of felt, you know, it's not a dirty secret, sort of thing. And the other, was that at the time, it was sort of...I heard that I was being discussed at Playcentre and I just felt that one way to stop all of that is to shout it from the rooftops if you like, that it's no big deal then...that it's nothing...everybody knows about it, you know.

Patricia took the view that if their DI conceptions were common knowledge, they would not be the subject of "gossip", illustrating the contention that gossip increases whenever information is both scarce and desirable (Bok, 1984:91). Patricia's concerns reflect the normative point of view which often stresses the more negative evaluation of gossip (Bok 1984:90). Bok claims that this view neglects to take into account that everyone has a special interest in personal information about others, and the need to inquire and to learn from others' experiences (Bok, 1984:90). While Bok concedes

that some gossip can be harmful, before proceeding to examine what makes gossip more or less morally problematic, she prefers to define it as “informal personal communication about other people who are absent or treated as absent” (Bok, 1984:91).

Patricia and Neil’s decision to tell their story in a national magazine also illustrates Goffman’s contention that there are many ways of managing stigmata (cited in Manning, 1992:98-99). Goffman maintains that concealment is the simplest solution, but this is often a tacit acknowledgement that the stigma in question is as discrediting as is generally assumed. A second way of managing a stigma is by using a “cover” which is a way of passing in the community by acting in an expected way (i.e. passing as the biological parents of one’s child) (Manning, 1992:98). A third, quite different strategy for managing a stigma is disclosure which is achieved by either flaunting a symbol of the stigma, or the stigma itself. According to Manning (1992:99), Goffman noted that this transforms the stigmatised person from someone with difficult information to manage into someone with difficult situations to get through. In this view, the difference is between a person who is discreditable and one who is discredited.

Patricia’s concerns about being the subject of whispered gossip were echoed by parents living in small rural townships (such as Annie and Andrew and Helen and Patrick) who chose what Goffman would have considered the simplest solution to manage or hide a stigma and to avoid being the subject of gossip: concealment (Manning, 1992:98). Since disclosing about their experience of DI in the women’s magazine, Patricia reflected that she too had adopted a more ‘secretive’ stance in other contexts such as in her parenting group. This suggests that secrecy and ‘openness’ are not mutually exclusive, and that different spaces open up or close down opportunities for certain conversations to take place or not take place (Plummer, 1995). Disclosing through a magazine article or through a newspaper birth notice are different social and relational contexts from disclosing face-to-face in a parenting group, and might elicit different responses. Since publishing their story using their own names, Neil and Patricia had since featured in a similar magazine story, but this time anonymously.

Neil: The following year we had some contact from a journalist, ah, who wanted to use that story and initially we said "Yes, that's OK. You can use our real names." And then we phoned back and said, "Well no. Make up some names. We didn't really need to be in the public spotlight in that way all the time. And it wouldn't have diminished the story in any way."

Neil and Patricia's desire to tell their story anonymously in the second magazine article revealed that they were both 'open' and secretive. It also illustrated that when disclosing, there is always a need to preserve some degree of privacy to maintain control over one's identity and private life (Bok, 1984:12).

### **Disclosure as a means of soliciting and giving support**

Some parents of children conceived by DI said that they told others about their infertility problems and DI treatment as a means of gaining support from family members and close friends. Diane and Chris said that they told their parents and siblings in the early stages about having DI and informed them of the various stages of their treatment as they proceeded. Diane said:

Diane: All the years that we were involved with it, they sort of were informed right through, so it was just a natural progression, the various steps, so they were sort of behind us all the way through. And the same with our friends, all our close friends know about it as well, and they were the same. They knew what was going on through the various stages.

Diane claimed that conceiving a child by DI was a positive experience for them. One reason for participating in this research, they said, was to help others who might be contemplating having a child by DI. Joe and Ella claimed that by sharing information about their DI treatment, they had helped others who had contacted them as 'experts' on fertility treatment. Similarly, Carla talked about being able to help others by being 'open'.

Carla: I did a course at Polytech, and I said to one of the guys there, "Do you have children?" and he said, "No". And, I could tell by the way he said no, being a person who's been infertile, that there was a problem there. And I just started talking to him and chatting, and said that my daughter was a donor insemination daughter, and it turned out that they were going through the same thing. He talked about it from his perspective and it was almost like a relief to him that there was somebody that he could talk to. So, that's been great. And you do find that there are other people who have been infertile, or who don't have children, [for whom] it's great to find a soul person.

Carla and Ben had initially been secretive about their attempts to conceive by DI, but found that they gained more support and sympathy from others by telling them about it. Carla said:



Carla: When we were having the donor insemination to start off with, we didn't tell anybody, but people were wondering why we were stressed or tired, and sometimes... I remember at a party somebody saying to Ben and I, because we'd been married for seven years and still didn't have a child, that we were the most selfish people that they knew. And here we had been trying for two years at that stage to have a child, and it just cuts you off, and you think, "Oh!" And we didn't want to tell people that we were struggling away to try and have this child.

Carla and Ben's experience suggests that when people do not have children, others assume that they have actively chosen to be childless, and somehow are shirking an expected adult responsibility. This contrasts with Cameron's (1997) finding that involuntarily childless people in New Zealand sometimes reported that others assumed that they could not have children. According to Cameron (1997:63), studies have shown that it is a moot point whether those who choose not to have children are 'selfish'. It could be argued, she says, that having children is the most selfish act, because no child asks to be born, and having a child is totally for the self. Supporting this view, a mother who had given birth after many years of infertility, recently told me that she viewed having her child as a form of self-indulgence, in contrast to her former involvement in community work.

Some parents commented that they had told others about their child's DI conception so that they might become protectors or advocates for them and their children. Henry, who was familiar with the practice of artificial insemination in livestock farming, said:

Henry: Once or twice I was talking to mates and they've said something about Jack or Luke seeing them run around and actually I'll say they're AI donors. And they go, "Oh, are they?" I'm glad I do tell them because it's something I used to worry about. And I feel as though by including them in my world, that they'll be protectors for Jack and Luke too.

Similarly, Petra and Jennifer said they believed that it was best to be open and "up front" about their lesbian parenting. By adopting this strategy they avoided situations where they would not be made welcome or supported. They said about their views on secrecy:

Jennifer: There's no-one who I would keep it a secret from, because I felt like keeping it a secret. I think it's best to be up front, say it like it is, everyone knows where they stand. It's a much easier way of dealing with it.

Petra: Because, then, what power have they got? I mean there are a few psychos out there who might really, really hate you, but we're safer if we've got lots of people who know, who will

defend us. Like your [Jennifer's] stepfather, he's a case in point, I mean he's a bit of a redneck really, but he would defend us to the death, because we're his.

Jennifer: My stepfather was the most homophobic person that I'd ever known until I came out to him. And now he professes undying love and support for us. Now, that's a story of conversion.

Petra: And he'd do it anywhere...he won't...yeah. I would feel completely confident that the people who we know and trust will not be bad-mouthing us elsewhere.

Patrick had not disclosed to others about his sons' conception until the issue emerged spontaneously in a 'therapeutic' context. Patrick was undergoing medical rehabilitation after suffering head injuries in a car accident. He said:

Patrick: The only people I've told was in therapy. Therapy is part of my rehabilitation after one of my accidents. Part of my rehabilitation was to do with communicating. We were having one session and I just started crying, and my therapist asked me why and I said, "I'm just so happy." I was just feeling emotional in that session, and I said that my wife was pregnant, and he said, "What's so special about this?" I said, "It's not just that my wife is pregnant, it's the fact that I, myself, can't have kids." I don't know why I said this to him. But I've been going to my speech therapist for a long time.

This episode reveals the contingent nature of disclosure. It also illustrates how therapy "works". In his every-day life, Patrick had not talked about his infertility, but amongst the 'friends' he had made in his 'rehab team', he felt freer to express his emotions.

Disclosure was used by some parents as a means of sharing the burden of infertility. Joe, father of three sons conceived by DI, said that he had told many people about his infertility and his sons' DI conception. Joe and Ella said:

Joe: Yeah. It wasn't any great secret.

Ella: Everyone knew...well, most people knew.

Joe: Hit the handle bars once too often (he laughs). ... I'd be totally comfortable telling anybody...anybody who wants to listen. It's probably part of my therapy.

KH: So, would you, for example have told people at work?

Joe: Yeah. Oh, totally.

Ella: Would you?

Joe: Oh yeah. Friends. Even friends, you know, I play in a band and I'm sure they all know...well, the ones who I talk to, you know. I won't say they all know, but I don't bother talking to some of them. Not because I don't want to, it's just that I don't get around to talking to them.

Joe had told several friends and even work colleagues about his problems with infertility and found it therapeutic. He also used humour, seemingly as a way of

coping with his infertility. Ella, however, was not entirely comfortable with the fact that he had told so many people, though it appeared that she had never strongly asserted this view.

As well as telling friends and acquaintances face-to-face, Joe had also made a public announcement about his two youngest children's donor conception in the newspaper birth notices because, he said, by that time "we had got used to the idea of people knowing that I fire blanks". He said:

Joe: Well, in the birth notices we put, with thanks to... originally it was AID [artificial insemination by donor], and everybody got confused with the more common meaning for AID [AIDS].

Ella: You put, "Thank you to the AIDs" and it sounded like we had AIDS or something (we laugh).

Joe: People looked at me for a while and said, "Are you all right?" (he laughs).

Joe appeared to flaunt the stigma of male infertility, possibly suggesting that, like Neil and Patricia, he had chosen this particular method of stigma management (Manning, 1992:99). Although Joe and Ella said that they planned to tell their children how they were conceived, they had not yet done so. As a result, Ella was concerned that others who knew might tease their children, or that they might hear about their donor conception from others first.

Ella: The only thing that worries me about telling lots of people is that like, say, I tell the neighbours down the road and then their children tease our children saying, "Your dad's not really your dad." That's the only thing that really worries me, because you know what children are like, and until our children understand, I'm really a bit scared of that. I can just imagine the Jones's down the road... they've got two older boys and I can just imagine Paula and them talking and the children hearing them and then...

Joe: Yeah. But it's probably not something that they discuss.

Ella: No, but you could understand how it could accidentally happen.

Joe: Ah, yeah, personally...the chances are pretty remote though.

Ella: Mm. Apart from that, it doesn't really worry me.

Joe's denial about the likelihood of others telling their sons about their conception before they did is contested by the existence of public narratives about people who were adopted being psychologically harmed by hearing from others about their birth parentage. Knowledge of such stories no doubt contributed to Ella's unease about the number of people to whom Joe had disclosed. Joe's openness contrasts with Andrew's

desire for secrecy, discussed at the beginning of the chapter, but also illustrates that these are different strategies used in the management of stigma.

While couples like Joe and Ella and Andrew and Annie illustrated incongruence in the desire to tell others or not about their experiences of infertility and DI, Nachtigall et al.'s (1998:1166) study found that there was no association between disclosure status and gender. However, in this study, more women than men claimed that they had more of a "need" to talk to others about their infertility-related problems than did their partners. Sean, who had not discussed with others his infertility or their use of DI, but knew that his wife had told others, raised the issue of difficulties arising for him because he did not know who among their friends knew, and who did not know, about their daughter's DI conception. He said to Pippa:

Sean: The only thing that I've found hard, is that you've told some people I think, and I was never entirely sure who.

Pippa: I think probably because...I find it hard...I needed to talk more than Sean, because Sean's not a talkative type. But then apparently that's a male thing.

Sean: There's nothing to talk about as far as I can see. It's a small plumbing problem.

Pippa: But there are issues that I needed to talk about and Sean didn't.

Sean: I mean, I don't mind you talking to people. I still, to this day, don't know who knows. So I don't know how to speak to people.

Pippa: Well, everybody that you know knows.

Sean: Sorry?

Pippa: Zita knows but Pierre doesn't.

Sean: Yeah. But that's really hard. I mean, what do I say to Pierre?

Pippa: Nothing. Just don't say anything.

Sean: Yeah. But things come up, like, "they look like you", or...

Pippa: Well, you can tell Pierre! You can tell Pierre if you want to tell Pierre. And I only told Zita, because Zita actually guessed. I don't know how.

This exchange between Sean and Pippa indicated the tensions that can emerge between couples around secrecy and disclosure, even if they have generally agreed about disclosing to others. It also illustrated a lack of congruence in their "need" or desire to tell others about issues surrounding infertility and having a child by DI. This situation also indicated a lack of communication between the couple about what

information had been shared and with whom. Pippa gave conflicting responses to Sean's questions and appeared irritated by the situation, which had become an "issue" when she would rather it had not. Pippa's remark about only telling because her friend had guessed highlights the relationship between disclosure and contingency: she disclosed to her friend because her friend had guessed that they had had fertility treatment. To deny it in that situation might have felt like lying rather than not disclosing. The difficulty was that this event had further consequences, including for Sean, who remained unclear about whom she had told.

## **Conclusion**

As a medical treatment for male infertility, DI has traditionally been shrouded in secrecy. DI has been regarded as morally suspect, and negatively associated with the stigma of male infertility, illegitimacy and adultery. Secrecy has reportedly served to protect the interests of the parties involved in DI conception (donors, recipients and their children, as well as health professionals engaging in DI practices) from social stigma and retribution. In recent years, however, the secrecy surrounding DI and the lack of information available, particularly to individuals conceived in this manner, have been subjected to a strong critique. This has been fuelled by research evidence that adopted persons were psychologically disadvantaged by secrecy, and benefited from receiving information about their birth parents. The trend towards open adoption and the growing strength of 'rights' discourses have thus informed debate about the right of the child conceived by DI to know about his/her genetic origins.

Use of the terms 'secrecy' and 'openness' have also been critiqued on the basis that these terms set up a binary opposition, are value-laden, and simplistic in that they represent absolute positions that do not accurately reflect social practices. As a result, the term 'information-sharing' is more commonly used to frame patterns of disclosure and non-disclosure about donor conception. Debates about information-sharing centre on the conflicting 'rights' and 'needs' of all the parties involved. Drawing on the work of a number of theorists on secrecy and privacy, two separate but related concepts, this chapter has illustrated that conflicts over secrecy are not so much about the secret itself, but the power to control the flow of information.

The chapter illustrated that secrecy and disclosure are embedded in sets of social relations. Power struggles over controlling the flow of information about DI were more apparent among couples who reported differing definitions of secrecy, and different 'needs' with respect to sharing or not sharing the information about their children's DI conception with others. Some men used secrecy as a means of protecting their self-image or to avoid the stigma attached to male infertility and the use of donor gametes. Men's desire for concealment of information, even from close family members and friends, caused conflict in some couples' relationships. Women generally perceived themselves as more 'relational' than their male partners and considered that they had a 'need' to share this information with significant others. Some women experienced conflict between the desire to protect their husbands and families from social stigma, and the desire to be honest and share information about a significant event in their lives. The difficulties that emerged for some couples, as a result of the conflicts over secrecy, illustrated the dangers of secrecy: it can be a barrier to intimacy and personal development, become obsessive, impair judgement and negatively affect others (Bok, 1984).

Issues of secrecy and disclosure revolved around issues of trust, intimacy and honesty. Parents who were inclined to keep the information a secret tended not to trust others, expected that they would react negatively or use the information in a way that would harm them or their child, or would not keep the secret. Secrecy was thus a way of protecting relationships and maintaining the status quo. Non-disclosure, however, was also used as part of an adaptive process. Some couples kept the information from others while they evaluated their situation and established social relationships with their children. From this more secure position, they felt more willing to disclose. This illustrated that, for some, the perceived risks of telling became less significant over time, the perceived 'need' of others to know intensified, and revelation was perceived as less of a risk. This indicates that patterns of secrecy and disclosure are variable, change over time and contingent on a multitude of factors relating to the nature of people's familial relationships.

For many couples, non-disclosure was more a matter of privacy and confidentiality than secrecy. Maintaining privacy enabled them to share the information only with those whom they trusted to treat the information in an appropriate way and to be

supportive of their actions. Decisions about disclosure or non-disclosure were thus made in the context of the web of social relations in which couples were embedded. While many couples revealed information about their infertility and their child's DI conception to close relatives and friends, many were uncomfortable telling others in semi-public arenas, such as at antenatal groups, or in the workplace. This illustrated that the secret was about a personal or private matter. It also illustrated Simmel's (1950) contention that secrecy occurs in social conditions of strong differentiation and that the secret embodies and intensifies such differentiation. Non-disclosure in these contexts revealed how privacy works as a means of impression management. It also illustrated that privacy protects self-identity and that knowledge about one aspect of life can disrupt identity in another setting, such as the workplace.

Patterns of disclosure and non-disclosure were dynamic and contingent processes, embedded in particular social and relational contexts. Giving the impression that they were having IVF treatment, rather than DI, was used by some couples as a tool of impression management. This illustrated that IVF was regarded as more positively associated with biological parenthood and the miracles of modern medicine, compared with DI with its more negative associations with male infertility and the use of donor sperm. This demonstrated how families manage stigma and that some stigmas, such as male infertility, are more easily concealed than others (Goffman, 1963:63). Other couples publicly announced their use of DI, at a particular time, illustrating that couples use different forms of stigma management (Manning, 1992:99). Disclosures to 'everyone' were generally preceded by situations that threatened people's agency or self-identity. Relinquishing control of the flow of information about DI, however, subsequently increased vulnerability and reinforced the desire to regain some control over the flow of information about their private lives.

The complexity that emerges when analysing patterns of disclosure and non-disclosure about DI raises issues for policy and practice in this area. Clinics may advise 'openness', but the complexity of people's familial relationships, and changes that occur over time should be acknowledged. Appropriate strategies for managing disclosure and non-disclosure that take into account their individual family circumstances might usefully be discussed with recipients. Gender disparities are

apparent in relation to disclosure and non-disclosure. These differences and ways of managing such differences might be discussed in counselling sessions with recipient couples prior to treatment, or in follow-up sessions. While not fully explored in this study, couples' disparate attitudes towards and practices related to secrecy and disclosure indicates a topic for future research in this area.



## Chapter Nine

### Telling Conception Stories

My mother did not tell me of my origins until I was 37 years old (in 1983), a few days after the death of my younger DI brother. My dad died the prior year. The details of the revelation are not important. My reactions are. Within the space of a few minutes, I was confused, angry, relieved, hurt and embarrassed and yet full of sympathy for my parents. In the first place, I had long suspected that my dad was not my genetic father. At five years of age I had asked my mother if I were adopted but she said, “No, you’re my child.” - A. William Cordray (1997:35), *Let the Offspring Speak*.

#### Introduction

As discussed in Chapter Eight, perhaps the most complex and controversial issue in AHR, when donor gametes are used, is whether or not the child should be told of his/her donor origins. The secrecy that has traditionally surrounded DI practices has created significant blocks to the flow of information between parties involved in donor conceptions and, ultimately, to children born of such arrangements. As outlined in Chapter Eight, secrecy and anonymity have ostensibly been deployed as a means of protecting the interests of the parties involved in a DI conception: donors, recipients, offspring and the clinicians (Haimes, 1993c; Daniels and Taylor, 1993a). Thus, the practices of secrecy and disclosure in relation to the child conceived by DI need to be considered in the context of the complex web of interests that historically have supported the maintenance of secrecy and anonymity.

The medical profession has had long-standing vested interests in maintaining secrecy about DI. Traditionally, medical students were used as sperm donors and the profession has sought to protect the medical institution from public scrutiny and criticism about the morality of creating families using the gametes of third parties (Haimes, 1993c; Daniels, 1998:79). Amongst medical practitioners, donor anonymity has also been regarded as a means of ensuring a supply of donor sperm: the assumption being that men would no longer wish to donate semen if their identity were to become known (Daniels & Taylor, 1993a:158). Donor anonymity has also been strictly guarded because of concerns about legal liability in relation to the child, and amidst fears of possible future intrusion into a donor’s own family by DI

offspring. At the same time, anonymity has also been regarded as a means of preventing unwanted intrusion from donors into recipient families. These concerns support Haimes' (1992:136, 141) contention that the elaborate devices used to preserve anonymity in DI indicate the significance attached to genetic ties in Western society and how this is linked to ideas about family and, hence, to ideas about intimacy, social responsibility and social relations more generally.

Many couples with children conceived by DI have been advised by fertility specialists that nobody need know about their donor conception, and research has shown that many parents have chosen to follow this advice (Snowden, Mitchell and Snowden, 1983). These authors stated that many couples interviewed for their research suggested that because the mother went through what appeared to be a 'normal' pregnancy, nobody, including the child, needed to know of the 'special' circumstances of conception (Snowden, Mitchell and Snowden, 1983:101). Research has also shown that some parents of children conceived by DI have opted for non-disclosure in a bid to protect their children from the stigma of being 'different', that is, not conceived 'naturally' (Achilles, 1986:82). Many also opt for secrecy and anonymity to protect the child from finding out that their father is not their 'real' father, and from the confusion that might result from having two 'fathers' (Snowden, Mitchell and Snowden, 1983; Blyth, Crawshaw and Speirs, 1998:70).

This reasoning nonetheless raises the question of whose interests are in fact being protected, and also raises the morally problematic spectre of paternalistic lies (Bok, 1978: 212-213). While pointing out the problems of paternalistic lying, Bok nonetheless acknowledges that the consequences of telling children certain 'truths', such as their biological origins, are not uniform. She asserts that "most, if told the truth, might well agree that they prefer to know; but some would grieve and wish that they had never been told" (Bok, 1978:217). Paternalism, however, has been criticised by protagonists of information-sharing in DI (Daniels and Lewis, 1996). A number of adults conceived by DI have spoken out against the secrecy, lies and deceit

surrounding their conception that they claim has negatively affected their lives (Cordray, 1995, 1997; Whipp, 1998; Turner, 1999).<sup>1</sup>

Arguments in favour of protecting children from the knowledge of their DI origins is contested by anthropological research which suggests that children can maintain knowledge about their 'birth' parentage while experiencing parentage within a kinship system which is not restricted to biological ties (Carsten, 1998:1).<sup>2</sup> Non-disclosure to people born by DI has therefore become increasingly subjected to criticism, particularly by social workers, psychologists, counsellors, and also by doctors, on the basis that it deceives human beings about a fundamental aspect of their identity: their genetic origins (Baran and Pannor, 1989; Daniels and Taylor, 1993a; Landau, 1998).

Arguments in favour of disclosure to the child conceived by DI, and a movement away from complete donor anonymity in some countries, have arisen partly in connection with changes in attitudes towards adoption (Cohen, 1996:89). According to Cohen (1996:89), although DI and adoption have significant differences, both involve the rearing of a child who is not genetically linked to at least one parent, and as a result, frequent linkages between the two have been made. Haines (1988) reviews the linkages between adoption and donor conception but claims that while adoption might be a useful precedent, this is more because of the questions it poses than for the provision of solutions for direct application. Arguments made in the adoption literature about the child's 'right' to know about his/her biological and family origins, and the importance of knowing these to the construction of one's identity, are invoked in arguments about the right of the child conceived by DI to knowledge of his/her genetic origins (Cohen, 1996). Proponents of information-sharing also invoke arguments about the psychological harm caused by deception and secrecy within families (Baran and Pannor, 1989; Daniels and Taylor, 1993a; Landau, 1998). Thus, some argue that secrecy, anonymity and deception in DI are not only psychologically and socially harmful, but also ethically unacceptable (Landau, 1998).

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<sup>1</sup> A variety of other accounts by individuals who have learned about their DI origins also appear in Donor Conception Support Group (1997); Blyth, Crawshaw and Speirs (1998); and Franz and Allen (2001).

<sup>2</sup> Carsten (1998) argues that what defines the identity of a child is highly variable cross-culturally. Amongst Malays and in other south-east Asian cultures, for example, the acquisition of identity is rather fluid and is not simply determined by birth or parentage. While blood is highly significant in

This position is reflected in laws governing AHR relatively recently instituted in some countries.

Sweden, in 1985, was the first country to give donor offspring the legal right to access information about their donor when they reached ‘maturity’ (Blyth, 1998). Other jurisdictions to follow the Swedish example were Austria, in 1992, and Victoria, Australia in 1995 (Australian Government, State of Victoria, 1997). According to Blyth, the latter “provides the most comprehensive legislative framework regulating access to genetic origins following donor-assisted conception” (1998:73). Most recently, Switzerland has instituted laws on medically assisted reproduction, which ensure that people conceived by DI have access to identifying information about donors (Switzerland, 1998). In many other jurisdictions, including Spain, Denmark and France, donor anonymity is protected by law. In countries where no legislation is currently in place (such as Canada, The Netherlands, Italy) non-identifying information about the donor may be accessed, but identifying information is only available in ‘extraordinary’ circumstances (Blyth, 1998). Thus, overall, international reviews of regulations relating to AHR reveal a lack of consensus in several legal and ethical areas, including access by individuals conceived by DI to information about the gamete donor, the kind of information available, and the keeping of donor registers (Daniels and Lewis, 1996b; Blyth, 1998).

### **Information-sharing in the New Zealand context**

New Zealand has come to be regarded as a “leader” in information-sharing about DI, particularly in connection with telling the child conceived with donor gametes of its origins (Daniels & Lewis, 1996b; Watkins, 1999). This position has been assessed as a positive development by advocates of information-sharing (MCART, 1994:69), but has also been described as a dangerous experiment by one British medical specialist (Daniels & Lewis, 1996b:57) who presumably opposed information-sharing. This possibly relates to arguments that support the natural-social divide and the idea that anyone attempting to cross these boundaries is ‘dangerous’, because they cannot easily be categorised (Haimes, 1988:55-56). Given the history of the dominance of discourses about the need for anonymity and secrecy in DI, a stance favouring

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these cultures in relation to ideas about kinship, blood is not just genetically determined, but can be formed in part by food.

information-sharing could certainly be regarded by some as venturing into risky and uncharted waters.

In view of the socio-political context in which DI is practised, this chapter examines the policies of two New Zealand fertility clinics in relation to their philosophy of 'openness' and advocating the need to share information about DI conception with the child. It also reviews the perspectives and practices of parents of children conceived by DI in relation to telling them about their DI origins. This chapter draws on Rumball and Adair's (1999) New Zealand study of parents' patterns of disclosure to their children conceived by DI. These authors' quantitative study, which includes responses from 181 parents of children conceived by DI, illustrates how those who disclose often begin by telling children when they are young, later re-telling the story, thereby framing it according to the child's level of understanding (Rumball and Adair, 1999). Similarly, my research illustrates that telling the story of a child's conception is not a single event, but an on-going and evolving conversation (Hajal and Rosenberg, 1991). Like Rumball and Adair's study, the current study investigates whether couples have told their child how they were conceived, how and when they have told these conception stories and, if not, if they plan to do so in the future. It differs from Rumball and Adair's study, however, in that it highlights the complexities that emerge for parents in relation to determining if, when and how to tell.

### **Advocating disclosure in the clinical context**

In New Zealand, fertility clinics have moved towards a policy of information-sharing between the parties to a DI conception (Daniels, 1995). As a result, and as discussed in Chapter Five, most clinics recruit only donors who are willing to be identified in the future to any DI offspring. This has occurred in the absence of any formal policy or legislation which reveals the extent to which education and changing professional attitudes about secrecy have significantly changed in recent years. Staff, and particularly counsellors, at New Zealand clinics advocate that parents tell their child about his/her means of conception (Rumball and Adair, 1999:1397). When asked about their reasons for this advice, the clinical director of a New Zealand fertility clinic said:

Dr A: To a degree it was sort of the dogma<sup>3</sup> of the time. I think there are enough examples in the literature of situations where secrecy just doesn't work. And that applies not only to donor insemination but adoption and those sorts of issues. And that's the standard thing that people say, that secrets are wrong. Now, I certainly believe that it is the child's right to know, ah, I think there are children who don't know. I don't have any strong proof of that, but I'm pretty sure there must be. Again, it's what people say they feel they have to say. But I know the families in which the child does know and the way they function seems to be a much more... a much better way.

While Dr A believed that families who were 'open' functioned better than those who were not, he also recognised that disclosure might not always be the best option. He elaborated:

Dr A: I suppose, to a degree, there may be situations where that dogma may be wrong. I can't really think of anything, but nothing in our world is black and white. So the philosophy of the clinic is that it's the child's right to know. All of our donors that we have are in agreement that they may be contacted in the future. We tell everybody that. We can't guarantee that because there's no obligation for the donor to change their mind... not to change their mind. Well, I mean, we talk about it and they agree in that sort of way.

Closely linked to discourses about the child's 'right' to know their genetic origins are arguments about the need to protect the 'best interests' of the child. These were guiding principles for the Ministerial Committee on Assisted Reproduction in its consideration of the use of AHR in New Zealand (MCART, 1994:32). While arguments about the need to consider the 'best interests of the child' are often invoked in discussions about the ethics of assisted human reproduction, it is easy, nonetheless, to overlook the potential child in a clinical context. After all, the child does not yet exist and both the fertility specialists and the potential parents are primarily concerned with attending to the immediate problem: infertility and the couple's desire to have a child. When asked about this ethical dilemma for fertility clinic staff, a scientist working in a New Zealand DI programme had this to say:

Scientist: It takes a conscious effort to remember the child, and I'm sure it's not forgotten. I'm sure the nurses are quite conscious of this. In fact, with the discussion they always have with the parents about the need for openness and how it is really more desirable, that at an appropriate stage they do tell the child the truth about its origins, and the dangers of having these secrecy things in families, which perhaps are apt to come out at moments of stress rather than under controlled circumstances. And so to me that's probably the central ethical issue, this kind of balancing act of the interests of all parties involved.

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<sup>3</sup> The term dogma refers to a principle or tenet laid down by a particular authority which, in this case, relates to the literature on adoption and the harm caused by keeping secrets in families, and the importance for a child's identity to know their biological origins.

In the current New Zealand context, attending to the interests of all parties, including the child, means advising potential parents to be open and honest with their child about their donor conception.<sup>4</sup> While the situation varies between clinics, recipients are generally given non-identifying information about their donor(s) which indicates the donor's position on being identified at a later date.

Not all New Zealand clinics have a formal policy that donors be identifiable. A staff member in charge of recruiting donors at one clinic said:

Lab Technican B: We are one of the few clinics probably where it isn't mandatory at this stage. It's not mandatory but [donors] are certainly encouraged to think about it very carefully. I can honestly tell you that I don't have one donor at present who is not prepared to be identified. They sometimes say, "Well what do other people do?" And I say, "It's your decision, but most people do, but it's up to you." And some of them specify an age at which they'd be willing to meet the child, and some of them say they leave that to either the parents or just when the child is ready to do it. Yes, so they're happy. And so what I tell them is that the child or the people will make contact with the clinic and we will approach the donor, and then they can regulate, or control the situation. So they don't feel that things are out of their control.

Although all donors at this clinic had indicated that they were prepared to be identified, the implication was that they would want to have some measure of control over when and how any DI offspring would be able to make contact with them. This highlights the issue raised by Dr A that clinics cannot guarantee that a child will be able to contact their donor in the future because donors are not legally bound to keep their word that they will be available to meet their DI offspring in the future. Like couples who might agree, in the clinical context in which 'openness' is advised, to disclose to their child, donors might also agree to be identified. Later, however, because of their life circumstances, they may change their mind. Uncertainty therefore surrounds the prospect of donors being identifiable and available to meet any DI offspring who may seek contact in the future.

As discussed in Chapter Five, fertility clinic staff participating in this research advised couples in DI programmes on aspects of secrecy and disclosure to family and friends and the benefits of informing the child of its genetic origins. A clinical director said:

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<sup>4</sup> See Appendix C for information sent to recipients that states the clinic's philosophy on the advisability of telling the child.

Dr C: It's openness all around really. It's openness with families and friends. Some people have very difficult relationships, and it causes all sort of difficulties when a child comes into the world and the grandparents don't know. I mean there are people like that still I think. So, we do advise on that. And I think it's interesting whether a couple accept that and agree to it [disclosure], then don't. So it would be interesting to know whether they do.

Dr C's comments highlight the lack of control<sup>5</sup> clinical staff have over whether or not parents disclose to others about the method of their child's conception. Fertility clinic staff can espouse a particular perspective and attempt to provide tools to help parents disclose to the child and others, but ultimately recipients are individual agents who make their own decisions regarding secrecy or disclosure in the context of their own relationships. It also raises the issue of trust between clinicians and their clients: the possibility that recipients might agree to disclosure in the clinical setting, but in practice maintain secrecy.

In terms of addressing the issue of telling the child with prospective DI parents, a fertility clinic counsellor, who had been employed by the clinic for ten years, said:

Counsellor A: I ask what they think, without entrapment really, without trying to trick them into anything. And then I state quite clearly that as they're going through the programme we have a very overt philosophy of the child's interests. And I also tell them we are not...we cannot alter what you intend to do, because if you knew that you could only get on the programme by saying we'll tell the children, then you could tell me, we'll tell the children, and I'd say, "right you're on". And so I make it *really* clear to them that it is a *process*. Some people work it out really quickly before they...you know...as soon as they think of DI, they sort of have got this idea of the right way to do it, whichever way they go, that they'll sort of work it out. But it is a process. You can go into it and think, "Oh it would be impossible to do that"... to tell the child... but then, there's the pregnancy and then there's the actual child, and it's a process of working out what's best for the child. And I usually bring up, you know, in your relationship what things are really important? And, they usually say "honesty" or "trust" or something like that. And I say, well, I guess that's how we look at it here, that the relationship with the child ideally should be based on trust and honesty.

The decision to tell the child of its origins was therefore constructed as part of a particular 'journey' which might begin with the desire to be secretive, but then evolve to one where the focus is more the interests of the child. Counsellor A described the process:

Counsellor A: To start off with, it's the male infertility. It's protecting, and sometimes the woman colludes with that. Protecting that privacy, protecting that self-esteem, protecting that public image. And she often will collude with this, thinking that that is the focus, which it is at that time, but then the focus shifts to the children, and what's best for the children. What it is for

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<sup>5</sup> The focus on control here links to discussion in Chapter Eight about privacy and the control of information flow.



you fades into the background with what is best for the children. I often say that to them. I say to them, I can absolutely guarantee you, you know, looking at the two of you and seeing your relationship that you'll be doing everything in the best interests of your kids. Wherever you're standing now, *they'll* be the focus once they're here.

The counsellor also assessed the extent to which couples appeared to be receptive to the idea of disclosure more generally and, if they appeared somewhat resistant to it, she warned them of the potentially harmful consequences of harbouring secrets within families. If she thought recipients were “a bit closed” she would tell a cautionary tale about a person who had gone through a DI programme some years previously. Following the advice given at the time not to disclose, he had later suffered a “breakdown” as a result of “living with the lie”. Non-disclosure was thus constructed as a risky and potentially destructive course to follow.

In contrast, the counsellor at another clinic was more circumspect about advocating disclosure, preferring instead to discuss with clients both the “pros and cons”. She said:

Counsellor B: I have had a number of people whose parents' attitude has been “if it's not meant to be, it's not meant to be.” That can have a significant bearing on whether they would tell the parents. But they may want to tell the child but not tell other family members. That's a very difficult one. I spend quite a lot of time trying to get people to make the best decision for themselves. And those things can change over time as well. Some people have been surprised, pleasantly so, by other people's reactions. It's easy to imagine a bad reaction.

Counsellor B's reluctance to advocate a particular stance for or against disclosure highlighted the complexities surrounding the issues of secrecy and disclosure for parents of children conceived by DI as they negotiate relationships with their children and significant others. While she attempted to help couples decide what was best for them, she also discussed the issue of the rights of the potential human being.

### **To tell or not to tell?**

For some couples in this study the decision to tell others, including their children about their donor conception was fraught with conflict and ambivalence. Although most couples had told, or said that they intended to tell, their children of their origins some were unsure whether to tell, while others planned to tell, but did not know the ‘best’ way, or the ‘right’ time to tell their child. Similarly, Rumball and Adair (1999) report that couples who had given their children information about their donor

conception, chose to tell when ‘it just seemed right’, or when they believed their children could understand their stories.<sup>6</sup>

Parents of children conceived by DI varied in their approaches and the degree of uncertainty that they experienced in relation to making the decision about whether or not, when and how to tell their child(ren). When Andrew and Annie entered a DI programme, they did not see a counsellor. They had a “chat” with a medical specialist who advised them that it was better to tell the child of its origins than not to. At the time, Andrew accepted this as the best strategy but over time had become increasingly anxious about the prospect of telling his daughters, now aged nearly six years and two and a half years, about their DI origins. He said:

Andrew: That was a long time away, so I was quite relaxed about telling the child at that stage. I'm not now. It was easy at the time, but as time went on, it became more difficult, and I guess what has become more difficult is my realisation that I have to tell my kids.

I went and saw my doctor six months ago or eight months ago, to talk about the issue... I was getting stressed, stressed to hell about the whole issue, so I went along and saw him. And he basically said, well, it's my choice. He said that my personality was strong enough and my ability to communicate was strong enough to just do it naturally... that I had all those abilities. See, my own self-confidence disappeared when I couldn't have children, and it's taken a long time to get that back again. I'm not a very confident person now.

Andrew raised the issue of the lack of well-established and acceptable scripts for telling his children how they were conceived (Daniels and Thorn, 2001). While he did not believe that he had the tools or the self-confidence to tell his daughters about their DI conception, Andrew believed he had a moral imperative to tell them the truth. From what he had learned from talking to doctors, he decided that he *had* to tell his eldest daughter when she was seven which gave him a year and a half's grace. Thus, he constructed the event of ‘telling’ the children as a major obstacle that had to be overcome at a fixed point in his life. Given the stress and anxiety caused by the prospect of telling the children, I asked Andrew and Annie why they thought it was important for their children to know about their origins. They replied:

Andrew: Well it would be a terrible lie if one day I told them [a lie], and one day I died, and they'd look at my records. I mean, I keep things, okay. They'll look at my records and they'll look at my death certificate and they'll say, “Gee, Dad couldn't have kids, and he died of a related

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<sup>6</sup> Rumball and Adair (1999) report that, of the 181 parents who responded to their survey, 30% had given their children (who were all 8 years old or younger) information about their DI origins. Seventy-seven percent of those who had not told intended to do so in the future, and 17% planned not to disclose.

complaint,” testicular cancer, for example, which I’m at risk to, “Golly gosh. Hang on a minute. That means he’s not my Dad.”

Annie: Oh, I just think it’s about *them*, isn’t it?

Andrew: I don’t think that’s fair.

Annie: It’s not natural not to tell them. It didn’t ever enter our minds not to tell them really.

Andrew: I don’t think there was ever an issue of secrecy to them.

Annie: You’ve got to be honest with them. I mean, they’re our children. If you can’t be honest with your children, well you’ve got a big problem I think.

While Andrew imagined a scenario of being ‘found out’ if he lied to his children, Annie invoked a discourse of honesty and truth as a ‘natural’ phenomenon between parents and children. She drew on public narratives about the “huge” problems arising for adopted children who found out later in life the circumstances of their birth and the need to avoid a similar scenario for her children. Annie had already attempted to introduce the topic to her eldest daughter when she accompanied her to the hospital when she had their second daughter. She said:

Annie: [Hayley] gets around with babies up her jersey, when she goes to the hospital. She knows that... I’ve told Hayley that we were having trouble having children and needed to go to the hospital to get some help, and I’ve sort of explained we’re not just like a normal couple. So she knows that...that we had to go to hospital, and I thought that would be a good lead up, yeah, and I’m waiting for her to ask questions.

At such a young age, it is difficult to determine what Hayley understood from her visits to the hospital, or what sort of questions might later emerge. While he struggled with the notion of how to introduce the topic of DI to his children, Andrew nonetheless predicted that, having told them, he would then become more ‘open’. He said:

Andrew: ...you’ll find that once my children know, then I’m probably going to be quite open about it with them, and if they so choose, other people that they so direct to. So I’m going to be at both ends of the scale, I predict, in the future: being very secretive and very open. Annie will frown over there, but I’m on record saying this.

Andrew appeared to indicate that the act of disclosure was more problematic than the secret itself. Placing himself simultaneously at two ends of the secrecy-openness continuum, Andrew illustrated the way in which secrecy and disclosure are embedded in particular sets of social relations. Although he gave assurances that he would become more ‘open’ having disclosed to his children, given his past and current

position of maintaining secrecy, Annie appeared skeptical about his ability to position himself differently in the future.

According to a nurse working in a DI programme, concerns about when and how to tell are common among parents of children conceived by DI. As previously mentioned, one of the major barriers to disclosure is the perceived lack of availability of knowledge about an appropriate script for telling. One of the major sources of such scripts are the children's books written to help parents frame the story of their DI conception from an early age, 'My Story' (Cooke, 1991) and 'How I Began' (New South Wales Infertility Social Workers Group, 1988). Andrew and Annie were unaware of these children's books. A nurse referred to the usefulness of these stories as tools for telling children.

Nurse A: In a support group, it's usually been the more, most asked question - "How do you do it? How do you start?" And we usually suggest to them to have the book available, and use it really as a bedtime story or just a reading...story to read to them while they're young. So they can absorb what they want at the time and slowly it filters through. I think nothing could be perhaps more devastating to be sat down and told as perhaps a *teenager*. I think there are enough issues going on in a teenager's head without being told then that you're a donor child. So we do impress upon them the importance of telling them while they're young. So that they can slowly absorb what they want when they're ready.

Nurse A's experience of conceiving children through DI and telling them how they were conceived was valuable when advising other parents about how and when to tell their children. She said:

Nurse A: I think my own experience has been helpful when couples asked about telling the children, and I related my experience of how we told them, and what the response was, so that they don't think it's a frightening experience... that they're going to be totally rejected. I think that's what parents feel, particularly that there's going to be rejection. So I think that my own personal experience has been useful to them.

The suggestion is that parents are not only unsure how to tell, but anticipate a negative reaction from their children, just as some feared negative reactions from telling others. Steve and Jane claimed not to have discussed the issue of telling their twins who were four and a half years old. Their ambivalence and differing views about telling their children were apparent. In Chapter Eight, Jane's conflict about telling her parents about their twins' donor conception was discussed. She was also conflicted about telling their children how they were conceived. She explained:

Jane: I sort of don't really like to have to tell the children...that their father's not actually their genetic father, because I sort of feel that I'd hate him to get hurt. But he could possibly say that he's not hurt, but to me I sort of feel that that side of it, I think, is quite difficult.... It's sort of a stigma thing too isn't it? It's just like adoption, but I think with adoption less, yeah, with adoption it's a bit different, because people are... I don't know how to describe it really, sorry.

Jane highlighted the contention discussed in Chapter Eight that secrecy is used as a means of protecting the infertile male. Her comments that DI was less socially acceptable than adoption relates to Haimes' (1988:48) argument that the perceived asymmetry in the relationship between the parents of children conceived using donated gametes might mean that these families are regarded as even more unusual than families with adopted children.<sup>7</sup> Jane claimed that when they began DI treatment Steve was against disclosing to the child. She intimated that she had persuaded him to give clinic staff the impression that he agreed to it because the clinic had made it clear to them that this was preferable to "living with a lie". Steve obviously had concerns about telling the children about their DI origins and commented that he thought that it had the potential to tear families apart. He invoked an argument against telling the child on the basis of his personal experience of this claiming that his adopted niece had "rejected" his sister, her adoptive mother, in favour of her birth mother.

Nonetheless, Steve insisted that the twins would eventually be told, which suggested that parents feel the pressure to tell, or say they will tell, even when they have personal misgivings about it. When asked what he thought was a suitable age to tell the children, he replied:

Steve: I...looking probably to about 10 years of age, something probably around about that, a bit older; when they're starting to get more comprehension of what's happening around them in the world because their education, on-going education sort of thing. But at the moment they want to know a lot of questions about everything. They drive you batty. I mean to say, the fish up and died the other night, and they just didn't want to accept the fact... Why did it die?

Steve's concerns about when to tell support Rumball and Adair's finding that most parents who had not yet disclosed gave their child's age and inability to understand as their main reasons for choosing to wait (1999:1392). Contradicting her previous position about not wanting to tell the children, Jane then said she thought that the children should be told at a much younger age.

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<sup>7</sup> The problem of asymmetry in families with children conceived by DI is discussed in Chapter Eleven.

Jane: But I just sort of feel that 10 is, personally, myself, and you're probably different...as normal, we're like chalk and cheese. But, um, I sort of feel that 10 is too old. Yeah.

Steve: Too old? Why?

Jane: Because I think that children are a lot more intelligent... you know I believe in telling them...

Steve: But there's a difference between intelligence and comprehension though, dear.

Jane: ...about four. I'd like to know the ideal age actually. There must be something...in the contract (she laughs).

Jane was nonetheless unsure whether the twins were too young to be told or not. She said:

Jane: Justin and Leanne have actually sort of said to me a few times, you know they often say, "Who's your mum and who's your daddy?", and "Who's my daddy?", and I go, "Oh, all right" as if I'm telling a lie. Where did I come from, type thing, and that's when I feel, "Wouldn't it be good to be able to sort of pop it out?"... because they keep on asking the same questions all the time. It's comes, not every day, but they do often do that to me. So, I think that could be quite an opportunity to tell them, and then I think, "Well is it too early?"

Jane worried that if she told them, they might talk about their DI conception in a playgroup before they understood it themselves. Her concern about giving children information appropriate to their age and stage of life illustrates a point made by a fertility clinic counsellor<sup>8</sup> who said:

Counsellor A: I think children should have information related to their age of development, and you should be building up their story for them, so that in fact the penny drops for them. Around 11 or 12 they'll say, "Does that mean you're not my biological father?" or however bright they are, "Does that mean that it wasn't your sperm?" And you say, "Well Dan, you figured that out. Couldn't have done better myself." You don't encourage precociousness in children. That can be taken advantage of by others.

If Jane was aware of what constituted information appropriate to her children's age then she might be better equipped to answer their questions about how they came to be born without giving them the 'whole story' which, according to the counsellor, could be quite counter-productive. McWhinnie (1996) provides a resource for matching age-related child development issues, and suitable scripts for answering the types of questions raised by children at these times. Clearly, however, this knowledge is not within the grasp of all parents with children conceived by DI. The lack of knowledge about what constitutes appropriate age-specific information might lead

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<sup>8</sup> Rumball and Adair (1999:1393) also cite Dudley and Neave's recommendation that information shared by parents with children should begin at the children's level of understanding. Stories will need to be repeated and modified as the child grows up.

parents to think that they should wait until the child can cognitively grasp the concept of biological relatedness before they tell them about the circumstances of their conception. But this, in turn, begs the question of how parents are to know *when* their children are cognitively competent.

### **Tools for telling the child**

One of the challenges faced by clinical personnel advocating disclosure to the child is the provision of adequate information to recipient couples in donor programmes. Many programmes provide reading resources to help couples decide how and when to disclose, but little is known about the implications of disclosure for children conceived by DI, or the ‘best’ way for parents to proceed. A nurse working in a donor programme said that she provided couples with information collected to help them think about the issues involved in having a child by DI and how to tell the child of his/her origins.

Nurse A: In the past, when we were doing the appointments, we had a book list that we always sent out to couples, and it suggested that they had some reading background on the issues so that they are more prepared as to what’s involved. I also keep articles from magazines on hand that they can have photocopies of when the couples are being interviewed and their feelings on what it’s been like to tell the children. And it usually crops up again when they have children and the children are growing up. They probably think about it initially when they’re going on the programme, but they want to get onto the programme and then I think it lies dormant for a while, and then suddenly there’s the child and it becomes real and as it starts growing up the issue rises again. And we always tell them we have the book “How I Began” on sale available for them, which helps tell the child of its origins.

The clinical director of a fertility clinic commented on the difficulty of knowing how to advise recipient couples about how to tell their children how they were conceived. He said:

Dr A: I have always struggled on actually what to tell people to do, because I mean I don’t know how I would do it in that situation. But I suppose the best advice that I’ve found is to tell the child before it understands, because then it just becomes part of what they do. And I say that we have these books. [The counsellor] is pretty knowledgeable about those issues, and so, I don’t know the answer to that.

While Dr A did not claim expertise in this area, he drew on adoption discourses that suggest that children should be ‘told’ when they were young, so they have the sense of always having known about their donor origins. The fertility clinic’s counsellor advised couples to provide their children with information about the circumstances of their birth that was relevant to their age and stage of life. She said that she followed a

particular developmental model based on Piaget's age-related developmental concepts. This related to research that shows that children only absorb information relevant to their level of understanding (Rumball and Adair, 1999:1397). The counsellor said:

Counsellor A: I've got this developmental model of telling children. And it starts right at the first questions about who am I, where did I come from, or how was the kitten born, or whatever. It's the facts of life, which is all tied up with identity and who I am and that comes from maybe looking at photographs and seeing the two of them fancy free, then the bump, and you say "That's you in Mummy's tummy" and then there's the picture at the birth, and Daddy cutting the cord, whatever. And the first questions the children ask are, you know, how did I get out of Mummy's tummy? So you give them that story, and that's about four they start asking that. It's related to the cat having kittens, or someone else having a baby, or the second baby arriving. You know, how is that, four or five - how do babies get out of Mummy's tummy?

You give them that age-related story, pushing very hard, etc. And the next question is how did I get into Mummy's tummy? So they process the first bit, go away, sort of Piaget's developmental concepts, process that, next question is, and who knows what they'll be then, sixish? Five or sixish, depends how bright the kids are, how fast they process things. And, how did I get into Mummy's tummy? You give them the normal story, that's what I tell them. Daddies have the sperm, mummies have the egg, sperm and egg has to join together, and mummies and daddies are built so they can fit together really closely, sperm meets the eggs, and that's the beginning of a baby. That was the beginning of you, and then you add a rider in there, and that's how it happens, but sometimes it's not that simple for all mummies and daddies, but sometimes the doctors can help.

So, they'll take that in. They're getting a normal view of themselves, not a view that there was anything odd about their conception or themselves, so they get a normal view and then they'll ask questions, because you'll repeat it again, because a friend will have a baby, or I mean, it's the story of their life, so they will ask, and they'll say, "Did you have any help?" And you'll say, "yeah, we were trying for three years to have you, and we weren't getting anywhere, and then the doctor sent us to the special fertility centre," and you still don't give them... you always give them a little bit less than they're asking for, so they can process that, and then they can come back – "What sort of help did you have to have?" "Well, we were trying and trying and went to the doctor and found that Mummy could have babies, but Daddy had something or other. Then we went through a lot of operations to see if we could put it right, or they said that there was a special programme that we could go on."

So, you gradually build up this picture for the child that that was the way that they were conceived. That they needed extra help, the parents, for that conception. Whether this is the right way to tell people to tell their children or not, I don't know, but it seems logical to me. And having had an adopted child, who we told she was adopted right from the beginning, and had no idea of what that word meant, but at 8 or 9 the penny dropped that she had two mothers, and there seemed to be that insight, that light going on. And I've spoken to other people who say that around 8 or 9 they seem to have that facility to be able to puzzle things out, but you need to build them up. And I think you're disadvantaging children by giving them information that they don't understand, because they can say at school something that gets a reaction from other people that can be quite demeaning for the children.

In theory, because the information about donor conception is gradually understood over time, it becomes less of an 'issue' or a potential problem for the child to find out that an assumed biological link to the father does not exist. This follows reasoning from the experience of adoption which Counsellor A also has first-hand experience



of, as an adoptive mother. Research in the field of adoption has indicated that children who are told about their adopted status when they are young adjust well to being adopted and, while ‘naturally’ curious about their birth parents, are less likely to want to trace them because they regard their adoptive parents as their ‘real’ parents (Haimes, 1988:50).<sup>9</sup> The counsellor acknowledged that it was difficult to know whether this is in fact the ‘right’ way to tell the child, but to her it seemed logical and sensible and was relevant to her experience of telling her own adopted child of her birth origins. As a result, she was comfortable relaying this model to couples who sought guidance on what, how and when to tell the child about their origins.

The counsellor at another clinic also believed in this model of telling, but questioned whether she had the right to advocate this approach to telling the child of its origins.

Counsellor B: I’d say that of the people I’ve seen, it would be approximately two-thirds who would be in favour of telling the child, but sometimes there’s disagreement on that, not necessarily whether to tell or not to tell, but when. One person might think it would be better to tell when they’re teenagers, and the other might think it would be better to tell them when they’re young.

KH: Do you have any thoughts on that?

Counsellor B: Well I do have thoughts on that, and actually that’s probably the thing about this that I find hardest really. I’ve got a background in developmental psychology, and know how children learn about their background. So, I do believe that it would be better to tell them earlier on, tell them in small manageable chunks, and to have it as something that could just be taken on board as part of your own story about yourself, where you came from, so it’s not like a huge secret, or you’re told one thing before you get to fifteen and you’re told something else later. But I appreciate that’s not necessarily the way other people feel, and it’s not my place to tell them that that might be the way to go about it. And at the moment I don’t feel like we have enough research to be able to say, clearly, that this is what has been found to be best way to approach it.

Counsellor B therefore appeared to question that the ‘overwhelming evidence’ from adoption necessarily supported what should be recommended in the practice of DI (Haimes, 1988:51).

### **The process of disclosure**

Almost all the couples participating in this research said that they had told their child of its DI origins or that they planned to. The high percentage of ‘disclosers’<sup>10</sup> is significantly different from other studies of couples with children conceived by DI,

<sup>9</sup> See Chapter Ten for a more detailed discussion about the reasons why adopted people might wish to make contact with their birth parents.

<sup>10</sup> Equally, some parents who said they intend to disclose or intend to do so by a certain age, might not.

which found that most parents did not intend to inform their child of its origins (see, for example, Snowden, Mitchell and Snowden, 1983; Daniels, 1988; Leiblum and Aviv, 1997; Nachtigall et al, 1998; van Berkel et al, 1999<sup>11</sup>). The apparent acceptance of ‘openness’ towards children conceived by DI in New Zealand is consistent with the findings of two recent New Zealand studies. One revealed that 82% of couples having DI treatment intended to tell their children of their donor conception (Purdie, et al, 1992). The other found that 84% of respondents had disclosed or planned to do so (Rumball and Adair, 1999). It is interesting to compare this high level of disclosure or intent to disclose in New Zealand, with results of a Swedish study of disclosure patterns by parents of children conceived by DI (Gottlieb, Lalos and Lindblad, 2000; Lindblad, Gottlieb and Lalos, 2000). As previously discussed, Sweden was the first country in the world, in 1985, to introduce legislation that enabled DI offspring to identify their genetic fathers upon reaching maturity. In their study, however, Gottlieb, Lalos and Lindblad (2000) found that only 52% of parents had told or intended to tell their children of their DI origins (11% and 41%, respectively). The authors therefore concluded that compliance with the intentions of Swedish legislation were low, even though the number of parents willing to inform their children was high from an international perspective, and that legislation alone is not sufficient to change personal attitudes in a population (Gottlieb, Lalos and Lindblad, 2000:2055). These authors also argue that in light of the Swedish legislation, health professionals should promote disclosure, and provide adequate counselling and support to assist parents in making the decision to disclose (Lindblad, Gottlieb and Lalos, 2000:201).

The high number of disclosers in the current study undoubtedly reflects to some (unknown) extent the context in which participants were recruited for the research: through New Zealand fertility clinics, and the New Zealand Infertility Society, which advocate sharing this information with the child. Because disclosure to the child has become a dominant discourse in DI treatment, it is also possible that those who agreed

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<sup>11</sup> This last study compares attitudes of couples with children conceived by DI in studies conducted in 1980 and in 1996. Results showed that nearly 80% of respondents in each of the two years did *not* plan to tell the child of its origins. However, in 1996 significantly more couples said they would inform their child of its origins (in 1980, many had said they were uncertain). The numbers, however, remain small. In 1996, significantly more couples opted to be open with others about their use of DI and sought more non-identifying information about their donors than they had in 1980. Thus, the authors

to participate in the research were more likely to be 'open' than those who declined to participate. As discussed in Chapter Two, this exploratory study cannot generalise to the population of families with children conceived by DI. Nevertheless, it is important to note that the discourses that couples draw on to help them make sense of their lives and guide their actions are constituted by common and shared social understandings. As a result, it can be expected that people who embark on similar experiences (e.g. conceiving children by DI) at a particular time and place will draw on a set of discourses that are generally available to all of them to interpret their lives. This argument is supported by Williams and Popay (1994:122) who maintain that lay knowledge is both personal and social knowledge in the sense that shared knowledge informs the private understanding of an experience.

As a counsellor pointed out, decisions about secrecy and disclosure are part of a process that involves shifts and changes over time. Some couples who had originally decided not to tell, later changed their minds. Stephanie, the mother of three children conceived by DI, Liam, aged 12 years, Marcus, aged 9 and Louise, aged 7, had this to say:

Stephanie: We just went through all the traditional paths of everybody else that we weren't going to tell a soul. But it's just so unrealistic. Well, it's like all of those things, it's a grieving process. And then, as you go through the grieving process, and then you decide, yes, this is what you're going to do, and you're going to do it under these circumstances... and then you go on a bit further and you think, well, that's not very practical, and it's just an evolution. And I look at Liam now, and I think he is a person in his own right. He has rational thought, and all of those things, and he has an absolute right to know.

Stephanie raised an important point about the connection between the grieving process and the desire for secrecy and that having moved through a grieving process they then focussed more on the child, as a rational individual agent who had a 'right' to know how they came into being. Stephanie said that she first introduced her eldest son to the knowledge that he was conceived by DI when, after a television programme on adoption, he asked if his parents were his birth parents. She said:

Stephanie: Liam asked us, were we his birth parents. And again it was a television programme about adoption.

KH: So then you explained to him?

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of the study identify a trend towards greater openness which, they argue, reflects public opinion (van Berkel et al, 1999).

Stephanie: Yes. It was just an ideal opportunity.

KH: How old was he?

Stephanie: Four, yes, just four. You see, it's the time they ask the questions. Not necessarily that, but they're asking where babies come from and those sorts of things. And actually, I've asked the children do they remember being told, and none of them do. They all say, "Oh we've just always known," which is good, because it meant I achieved my objective.

While Stephanie wanted her children to grow up knowing about their DI conception, so that the knowledge did not emerge as a sudden revelation, some couples waited until their children were older before informing them. Mary and Brendan, parents of Jason, aged 12 years, and Clare, aged 10 years, told their children when they were 10 and 8 years old, respectively. Brendan claimed that they were always going to tell the children and that he had no difficulty with it. Mary, however, said she had found the prospect more difficult. She obtained a copy of a children's book on donor conception which they used as a tool for telling their children. At the time, Brendan and Mary invited the children to ask them questions, but said that none had yet been forthcoming.<sup>12</sup> Mary recalled:

Mary: It was a terrible issue for *us*, for *me*. I found it really hard to tell them. I just worried about it for months and months. But once they were getting older I thought well this is something that's there... they've got a right... you know... it's a selfish reason not to tell them. As much as you feel that you're, you know, giving away something when you tell them, it's your selfish reasons. You're not thinking about their feelings, and their right to know these sort of things. Because it's their body, and how would you feel if you were in the same situation? I think if I was in the same situation I would want to know. And I think that that was basically it. I thought, well they're old enough and they really have that right to know. They're people, they're not babies any more, that you... when you first have this you think, well this is a baby, and you're quite... it's yours, but once it starts to grow, it does have its own feelings.

Like Stephanie, Mary illustrated the way in which views on secrecy and disclosure can change over time. As a fertility clinic counsellor said, the interests of the child appear to take on a different meaning as he/she grows older and his/her individuality becomes more apparent. Mary appeared to think that as her children grew from babyhood she had less of a claim to 'ownership' of them and so non-disclosure appeared selfish. This indicated that non-disclosure is a tool to protect the parents rather than the child. It is also a question of ownership of the information: it is not just for the parents to own.

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<sup>12</sup> When Brendan's nephew also had a son conceived by DI, Jason, however, commented that he hoped he would be able to have children in the future. Mary said she replied that he should be "fine" because he did not have the same medical condition as the other men in the family.

Other couples chose to tell their children about their origins right from birth. Some said they felt more comfortable with this because it was a way of practising telling the child before he/she could understand anything about it. By having always told the child about his/her DI origins, parents such as Diane and Chris hoped that it would never become an issue for their child. They said:

Diane: When he was a very little baby, right from when he was born we used to tell him a story, "Once upon a time there was a mummy and a daddy and they wanted to have a baby and they were very sad...and they went to see a doctor...and blah, blah, blah. And just lately I've been introducing the fact, you know, "Once upon a time..." and adding in the fact that a special man at the clinic helped us, and as time goes on and he gets more understanding, because he's not really that interested in it at the moment... [Chris laughs] but if it's in there I hope it will gradually just become something that he's always known, you know, it's never been an issue.

Chris: We really find it hard to believe that he's even going to think about it or worry about it, or think it's an issue. It just becomes another part of life.

Rumball and Adair (1999:1395) report that participants in their study told similar stories to their children. Other parents of DI children began introducing the topic when they first began reading books to their children. Caroline and Mike introduced the children's book about DI conception, 'My Story' (Cooke, 1991), to their daughters when they were about 12 months old and had read the story to them many times since. They were not sure how much their daughters, Toni, now 8 years old, and Lucy, 5 years old, understood about the story. When asked if they had asked any questions about it, Caroline said:

Caroline: Oh, they have asked odd questions. I can't remember anything specific, but Toni said tonight that she... I was reading it to Lucy... I thought, well I'll just see what she comes up with, and she turned around and said, "Oh, that was a lovely story" basically, "but I don't understand it." And I thought well that's okay, you'll learn to understand it and I said to Toni, "Do you understand it?" and she said, "Yes, I understand it." Now, whether that was just a big girl talking I don't know, but I think she... she knows that she wasn't conceived normally, as such.

When asked why they thought it was important for their children to know their genetic origins, Mike said:

Mike: We don't want any secrets. They deserve better than to be not told something as critical to their makeup. Personally, they may or may not think it a big deal. We've undertaken to be a good set of parents and to have a good stable family environment for those critical years. And where they come from was just another one of those things that happened because we had no choice. And if we didn't do it we wouldn't have children. That's it... that's the whole... I mean, I've told the girls ever since we first held them and have been reading to them so they're never going to look me in the face and say, "You never told me." I've been telling them very frequently. They may not have understood it, but they could never say they were not told.

Mike's comments illustrated that disclosure could also be perceived as a means of protecting the parents: from possible future accusations that they had not told their children the truth. In their study of parents' disclosure to their children, Rumball and Adair (1999:1396) found that 20% of parents had talked to their children about their DI conception from birth. Some couples with more than one child conceived by DI took their older child with them to the fertility clinic when having treatment to conceive the second child, and used the opportunity to tell the older child that this was how they had their babies and formed a family. This raised a question about the 'best' way of framing the child's DI conception. Daniels and Thorn (2001) argue that a 'family-building' approach might be more useful than a child-conception approach. They suggest that parents telling the child a story about how they were conceived might somehow have the effect of setting them 'apart'. An alternative approach, they suggest, would be to tell the story of how 'our family' was created which places the emphasis on 'us' as a family rather than 'you' as a child (Daniels and Thorn, 2001). The question arises, however, whether this is really more than semantics because it still indicates 'difference'.

Helen and Patrick, who had two sons, Thomas, aged 4 years, and Connor, 9 months, said that they had already started telling the boys about their DI conception. Helen said:

Helen: We do tell them. I've got a book and it's a wee book about how the doctor can help you, but then I took Thomas with me [to the clinic] when we were having Connor. I told him that Mummy and Daddy want to have a baby and have to come to the clinic to be able to and that a man [a donor] was going to help us. I didn't tell him everything. So he knew right at the start that [the nurse] was going to help us, and I told him that this was how we had him. So, he was happy with that, and he was really intrigued by it all. Nothing's probably been said about it since we had Connor, nine months ago, but the book's always in the bottom drawer, and we read it to them from time to time. And we sort of think, if it's in the children's subconscious that when it comes time to actually really talk to them about it in detail, they'll be able to cope with that. It won't be such a shock.

Helen raised the issue that telling the child is part of an on-going conversation that involves telling and re-telling when opportunities arose (Rumball and Adair, 1999:1397). The question arises whether parents tell their children that DI is an unusual form of conception. Otherwise children might think that all babies are conceived this way which poses a different issue. The question also arises whether

older children conceived by DI help tell the story to younger children and whether this helps 'normalise' the idea of DI conception.

Some couples chose to develop their own scripts for telling. Sarah wrote individual stories for each of her children as a way of introducing them at a young age to the topic of how they came to be in their family. She said:

Sarah: The point of the stories was that the children would initiate how much information they wanted to have. And Charlotte's doesn't say she's donor, and it just says a special doctor helped, you know. But, yeah, we've been filling in gaps as Rob gets older and Rob now has good contact with his birth family, and we talk about his birth mother. We don't talk about the grandparents as being birth grandparents, and he knows that Grant, we try not to use the word birth father because we think it could be giving him too much... it's not necessary. You know, Grant was Jo's partner back then and Aunty Judy has got her story to tell when that day comes, and all Charlotte knows is that another nice man helped... a doctor.

Sarah expected her children to ask more questions about the circumstances of their births as they grew older and wanted more information. It is possible that she did not give birth-father information to the children because the birth fathers did not have social relationships with the children. Therefore, it was difficult to explain who they were. As an added complication, Phoebe's birth mother claimed not to know who the birth father was.

Other parents were concerned that they had given their child too much information too young. Joanna said that her son Todd, aged 7 years, appeared to be confused about what she had told him about his DI origins. She said:

Joanna: [The book's] always been in the bookcase. But I've always said, from when they were only little, that they're special and I tried to explain last year to Todd, because Todd wanted to know why [he was special] but then he got confused. He asked, "Why isn't Dad my real Dad and why have I got another Dad?" He just got totally confused. So I thought, I'll wait till he's 11 or 12 and sort of really sit down and talk to him about it. I always say he's special and things.

Joanna had always told her children that they were 'special', a discourse used by adoptive parents and also parents of children conceived by DI to make them feel that they were specially chosen or wanted, rather than 'different'.<sup>13</sup> However, when she attempted to explain to Todd why he was special he became confused because, at 7

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<sup>13</sup> The construction of the child conceived by DI as 'special' is discussed in Chapter Eleven.

years old, he was too young to understand the difference between biological and social ties. Solomon et al (1996) contend that children below the age of 7 years are unable to fully understand the concepts of biological inheritance. According to Piaget's theory of cognitive development, once the child reaches the concrete operational stage (7-12 years) he or she is more capable of logical thought processes and more reasoning (1955).

Like other parents, Jennifer and Petra had already started telling their 9-month old daughter, Olivia, about her origins. They said:

Jennifer: We've already introduced it. Like, when we read her stories at night and stuff like that, we'll tell her the story, you know, as a kind of "Once upon a time...". That's our story at the moment. I think the kind of stories that I tell her as she gets older will develop at the appropriate age, so it's not, when she's five or six, to suddenly sit her down and say "This is what the story is." It's something that's actually developed and evolved right from the start, so there's no great surprises.... It's like sex. I see it as being very, very similar.

Petra: That's right. Sex is not a secret from her, it's just a bit bizarre to tell her the facts of life now since she can't talk.

Jennifer and Petra therefore envisaged that Olivia's knowledge of her DI origins would emerge as part of her normal development, just as people learn about the facts of life and human sexuality as part of the process of growing up. The children's books designed to help (heterosexual) parents tell the DI child of his/her origins are not suitable for lesbian parents. Like Sarah, Jennifer had decided to write Olivia's story herself. She said:

Jennifer: One of the things that I will do for Olivia, is that I want to write her a life story book, so that she has her nice little book, with her story in it, and how she came into the world. It's basically a, you know, what's that book they have at the clinic?

KH: 'My Story'?

Jennifer: 'My Story', basically a 'My Story' but more appropriate with photos and whatever. So, that's what I wanted to do for her. And also so other people will know how to explain it to Olivia, like I'm really happy for people who are close to us to read it to Olivia as well, so that they know how to tell the story, and take the lead from us.

For Jennifer and Petra, part of educating others about lesbian parenting involved being 'upfront' both about being lesbians and about parenting in the context of a lesbian relationship. At the same time, the couples suggested that as their children got



older they would take a cue from them as to when to be 'upfront' and when to be more 'closeted'. Olivia's non-biological mother, said:

Petra: And once Olivia's older, I mean, that's why we have to be up front. I can never deny being Olivia's parent, you know. Once she's six, seven, eight, I must take a cue from her. If she wants me to be closeted, I can be closeted. If she wants me to speak up for her, I have got to be prepared to speak up for her.

Similarly, Ria and Sophie, parents of Lydia, aged 7 ½ months, said:

Ria: I think what beliefs we have now are our own personal beliefs, but it's all really going to change when it starts to affect Lydia, when she starts to go to school. If she wants to have her friends over and she's slightly embarrassed, I think that I would probably do her the courtesy of not blurting out anything to her friends, because I just know how cruel kids can be, and so if she goes through a stage of being embarrassed about it, then I'll just have to let her be embarrassed about it, and not be so out front.

Sophie: But it's amazing, there's been a situation last week at the pre-school when there were two girls playing mothers and fathers, and one of them was saying, "Oh, who's going to be the mummy?" And they were fighting over being mummy, and Jessica says, "well, I'll tell you what, why don't we both be the mummy?" and Tara said, "But you can only have one mum and one dad," and Jessica turned around and said, "Lydia's got two mummies!" So it all comes from being around it really. And, as I say, I think that once Lydia's older, it may not be so much out of the norm. There's probably going to be two or three other kids at school with two mums.

Sophie appeared optimistic that with more children being born to lesbian parents having more than one mother may become 'normalised'.

### **When donors are not identifiable**

The issues pertaining to disclosure about DI need to be considered in the context of DI practices (Haimes, 1988). As discussed in Chapter Five, what emerges is a picture of health professionals advocating disclosure to the child in a context where anonymity, at least initially, remains a primary organising principle for the two South Island DI programmes included in this study. While most couples had had children at a time when donors had agreed to be identified in the future, as discussed in Chapter Five, this could not be guaranteed. Some, however, had had children at a time when complete donor anonymity prevailed and very little information was provided about the donor. Children conceived by DI at that time are very unlikely to be able to identify their genetic father should they wish to in the future. When Stephanie and John conceived their eldest son, Liam, they were given scant information about their donor: his hair colour, eye colour and general level of education. For Liam's sake,

they tried to find out more by contacting the doctor who had performed the insemination, who had later moved overseas. Stephanie said:

Stephanie: He can't...the fact that he'll never know the full information saddens me, but fortunately he's able to cope with that...and we've said, well we've tried. We showed him the letter to prove we tried [to get more information]. We weren't actually seeking the identity. But, [the doctor] couldn't provide any more information. He said he couldn't remember. What a wimpy excuse, but never mind. But then we had to say to Liam, "That was the deal we accepted, and we had a choice - accept the deal or not have you. Which would you rather we did?" "Oh well"... no contest really is it? It might raise its head again if the other two choose to meet the donor.

That Liam will not be able to find out more about his biological father was somewhat troubling to Stephanie and John, but their choices were constrained by the system as it operated at that time.

When Kathy and her husband Joel sought to conceive by DI, the health professionals at the clinic they attended advised them to keep it a secret. Kathy, however, had no intention of keeping the knowledge of her donor conception from her daughter Melissa. Like Stephanie and John, Kathy had tried to find out more information about their donor, but was unsuccessful. Kathy was adamant that her daughter had the right to know more about her genetic father and wrote to the clinic after Melissa, at four years old, started drawing pictures of the donor. She hoped that Melissa would be able to find out more about the donor if she wanted to, but the clinic said they could not assist because the donor had not agreed to provide any more information. Kathy said:

Kathy: My concern all along has been in the interests of these children. What right do we have to...there is the contract of law that they enter into of anonymity with the donor, but where does the right of this child pop up? There's a whole bundle of stuff in there.

According to Kathy, Melissa, who was 10 years old, had asked questions about the donor. For example, she wondered whether he liked peppermints, like she did, because other members of her family did not. She also wondered where her thick blonde hair came from because her parents and her younger sister, Nicole, aged 8 years, all had very fine hair. Kathy said that Melissa had recently begun to ask questions about the meaning of 'blood ties' and human relatedness. She said:

Kathy: She did ask was the donor related to her and I had said, "Yes, by a technicality" and she said, "You should just give it to me straight," and I said, "Well, yes, by blood, yes." And I said, "How do you feel about that?" and she said "well I don't want him to be." At that point she

then asked was she related to her dad. I said, "Well, you're related to your Dad by social circumstances, and he's your Dad and always will be." And she asked if she changed bloods with Daddy and he changed it with her, would that make her related by blood, because I guess that solid connection, the blood connection is a close tie.

I don't know whether it's got anything to do with Nicole, that's her sister. Earlier in the year, probably in February, we were talking about blood and relatives and Nicole had very unwittingly let her know... we were talking about relations by blood and Grandma being related. It was nothing to do with the donor issue. And Melissa said, "Am I related by blood?" And Nicole had swung around in the room and said "No, you never will be." And she said, "Shut up Nicole, shut up. I didn't even need to hear that and I don't want to hear it." She had gone out of the room and she was mortified, absolutely devastated.

Kathy's claim that Melissa and the donor were related "by blood" illustrates that genetic ties are regarded as synonymous with 'blood ties' in Euro-American notions of kinship. This is illustrated by Cameron's (1990:34) New Zealand study which found that for many parents an important reason for having children was to continue family bloodlines, which assumes the sharing of blood between parents and their children and ensures the continuity of the family. This framing of kinship, however, sets up a rigid dichotomy between the biological and the social. As Carsten (1998:2) has pointed out, cross-cultural studies have shown that while blood is significant to ideas about kinship, in many south-eastern Asian cultures blood is not just genetically determined, but can be formed by the sharing of other substances, such as food. In these cultures, blood is a marker of shared identity between kin, but is derived from both 'biological' and 'environmental' factors. Moreover, as previously discussed in this chapter and in Chapter Three, in the context of assisted conception using donated gametes, ideas about what constitutes blood ties are undergoing significant changes (Carsten, 1998).

Kathy, who said that she had always talked 'straight' to her children, had only recently decided that she needed to modify the information she gave them, recognising that they were still young children. She said that she had first told Melissa about her donor conception when, at three years old, she had asked how she was made. Kathy recalled:

Kathy: At the time, she was three, and I was driving the car. And Joel was in the car at the time and she said, "So how was I made?" and I said, "You were made from an egg from me and a sperm from a donor." I explained that a donor was another man who had given sperm because papa didn't have enough sperm at the time. "How was Nicole made?" That was a sinking rock for me. I said that Nicole was made from a sperm from papa and an egg from me, and she said, "Oh" and she's always been aware of that unequitable thing in there...very much so.

Kathy's comments raise a number of issues. The situation she describes suggests that families who have children who are full biological children and children conceived by DI might have different issues to confront when telling because of the possible perception of an asymmetry existing between them. In the light of previous discussion in this chapter about the need to provide children with information appropriate to their level of understanding, it could be argued that telling a 3-year old child about sperm and eggs and donors is inappropriate. However, in Kathy's estimation, this was less "in-depth and personal" than talking about the particular contexts of the two conceptions. It raises the issue that for Kathy genetic ties were significant, and therefore, she also assumed that they would also be significant for her daughter.<sup>14</sup>

Melissa, who was present at times during the interview with her mother, denied being concerned that she was conceived by DI and her sister was not. However, she said she had recently worked out for herself that Nicole was her half-sister and she wondered why her mother had not told her this before. Kathy replied that she did not want Melissa and Nicole to feel that they were anything less than 'whole' sisters so she avoided using the term 'half-sisters'. As far as the donor was concerned, Melissa was curious about "little things" about him, but said she thought little about him.<sup>15</sup> Melissa seemed more concerned about her social relationship with her father. Her parents had separated when she was 4 years old and her father had recently remarried. Kathy claimed that Melissa was reluctant to go to her father's house since he had remarried. Her father now referred to his partner's 16 year-old daughter as his "other daughter". Kathy wondered whether Melissa felt her relationship with her father was threatened because of the lack of a biological connection with him. Melissa, on the other hand, argued:

Melissa: It's just that he's changed. He spends time with [his wife]. He spends time with her and he used to be able to take us places and buy us clothes and things, but now he buys [his wife] something first but if he doesn't have enough money he won't do anything for us. He's just changed.

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<sup>14</sup> Kathy's daughters, Melissa and Nicole, were present at times during the interview. On some occasions Kathy called Melissa in from the adjoining room to ask her questions relating to her thoughts about the donor and her relationships with her sister and father. Melissa was not present when her mother described how she told her about her DI origins. However, Kathy then called her in to ask her whether knowing that she and her sister had different biological fathers affected the way she thought about her sister. Melissa replied that it did not change the way she thought about her sister.

It appeared that Melissa's problems with her father were more related to her parents' separation, divorce and her father's subsequent remarriage and reconstituted family, than to her donor conception and the lack of a genetic tie to her father.

### **Waiting for the 'right time' to tell**

Whereas many couples had told their children when they were young about their donor origins, some couples were waiting for the 'right time' to tell. This supports Rumball and Adair's contention that parents chose to tell when 'it just seemed right' (1999:1392). Generally, they were not sure when that time might be. Most of those who had not yet told their children had sons rather than daughters. Tania and Mark, who had a 9-month old son, Levi, said that they expected they would eventually tell their son about his origins. However, Tania claimed that they had received little advice from the clinical staff on how to tell. She said:

Tania: They sort of said that it was important that the child knew, and to perhaps bring it up like an adopted child. But I thought there might be a support group or something like that for later on, but I don't think there is. They never said anything, but they just stressed that it was important that we did tell. There was one support group started up by a couple but they were having problems themselves, but I honestly received no information about how you might tell the child... I mean we'll sorta certainly tell him, but I've never really thought about what the consequences would be (she laughs). Since he was born I've said to him, "you're a special wee baby," but you don't think about... I don't think... because he's only a baby and he's too young to understand, and he'll probably be ten years old before he'll really understand what we mean.

The prospect of telling Levi about his origins appeared to be a distant abstraction for Tania. She did not feel well-equipped to know how to tell the child and had given it little thought. The couple did not see a counsellor when they entered the DI programme and Tania was unaware of the children's books that tell the story of DI.

Some couples said that their children had not, to date, asked them anything about the "facts of life" which might have provided an entree to the topic of their donor conception. Henry and Prue had not yet told their sons Jack, aged 8 years, and Luke aged 6 years, of their origins. They thought that the boys were too young to tell, and were not sure how they would approach the topic.

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<sup>15</sup> Other perceptions of donors raised by some children in the context of interviews with their parents are discussed in Chapter Eleven.

Prue: Right now I think they play silly wee games and say silly things and I think it's not a good time to tell them anything like that. I don't know when it will be a good time. It'll have to be perhaps in the next few years.

Henry: When they go on their first overseas trip (he laughs). Actually I've been thinking about that, and I really don't know how to start. We're probably waiting for the right time, and when is it and I suppose that's a common thing for all donor families. When do you sit down with the little fella and tell him? I think the sooner the better in a lot of ways, but then it's... I don't want to tell them when they're out of shorts and into long pants. I think that's too late. It's within the next year or two I think. Nine, ten years old is a good time for that.

Prue: Somewhere around there.

Henry: The thing is, once you tell them, there'd be a hundred questions.

Prue: Oh yes, you see (she sighs). That's... I'm not really looking forward to telling them.

Prue and Henry appeared to be putting off something they would rather not have to contend with. Their quandary raises the issue of the difficulty for many parents of children conceived by DI, who do not build the story into their children's lives from birth, of making decisions about when and how to tell their children about their DI origins.

Like Henry and Prue, Joe and Ella had not decided when to tell their three sons about their donor conception. Ella had read a book recommended to them, *The Gift of a Child* (Snowden and Snowden, 1984), which included information about telling children about donor conception and she said she was planning to buy a children's book about it from the clinic. When asked if they thought their children should know about the circumstances of their birth, they said:

Joe: I think so, yeah. It's going to come out eventually; better it come from our mouths than somebody else's.

Ella: I must go buy that book. I keep saying that. Life's so busy.

KH: Do you imagine it might be hard to tell them? How do you think you might introduce the topic?

Ella: Well, I find that, if they don't know the facts of life, how do you explain it?

KH: Have they asked anything?

Ella: Not really.

Joe: No.

Ella: It said in that book to say that they were special and keep emphasising that they are special children, but it never said why they're special really. Because they're all wanted, that's the main thing.

- Joe: That's the other thing. It wasn't by mistake that they arrived.
- KH: So you think you might tell them through the book?
- Ella: The thing is, at what age to tell them.
- Joe: It's one of those things you haven't thought too much about. We will tell them eventually, I suppose by the time they're 10 or 11 and they know the facts of life...that they'll be told.

Joe appeared somewhat resistant to telling his sons about their origins which stood in direct contrast to his openness with others about his infertility and his children's DI conception. The information about their donor origins was perceived as something that would eventually be shared with them. Ella was clearly uncomfortable by a suggestion that she had read in connection with telling the child about its origins which was to tell the child that he/she was 'special'.<sup>16</sup> She resisted the notion that they were 'special' like adopted children who also could be constructed as 'unwanted' by the birth parents (Iwanek, 1997:15-16).

The notion of waiting for the 'right time' to tell the child of his/her DI origins and having no particular plans to tell illustrates that 'telling' is by no means straightforward, even as a concept, "let alone as a feature of interaction within actual families" (Haimes and Timms, 1985:82). It also raises the question whether the parents will eventually tell their children and under what circumstances. Both Henry and Prue and Joe and Ella claimed that they would tell their children, and both implied that the age of about 10 or 11 years old might be a good time because by then they might understand the facts of life. This notion runs counter to advice given by a counsellor that children should be told *before* they understand. In light of prior discussion in this chapter, the question also arises as to whether the longer they leave it, the more difficult it may become to tell them and the greater the risk of others telling their sons before the 'right time' emerged.

Meredith, the mother of Daniel, aged 7 years, said that she had no plans to tell him about his DI origins.

Meredith: I'm not worried. If he finds out, it's the right time. And if he doesn't...

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<sup>16</sup> This conceptualisation of the child conceived by DI as 'special' is discussed in more detail in Chapter Eleven.

KH: So, you don't plan to tell him?

Meredith: I'm not going to make an issue of it. I don't think so.

KH: Would that be partly for Karl's [her husband's] sake as well?

Meredith: Um, yes, and also because, going back to the fact that he's an only child. And, you know, that's a bit different now too, because so many children have brothers and sisters to play with. And, you know, I don't want him to feel that he's different (hah) from other families. So...when he's older, he'll probably cope with it. He's a very, um, takes things to heart. Very sensitive. If somebody calls him a name at school, it doesn't upset him, but when I go in to see him at night, he'll bring it up and say, "Why did he say that to me? Why did he?" You know? He's not upset about it, but he doesn't let something go, and get on with the next thing.

Meredith had no wish to be proactive in telling Daniel but on some level was prepared to leave it to 'fate' as to whether he found out or not. She was aware that her son had a classmate who knew the circumstances of her own DI conception and she had wondered if he might somehow find out through her.

## Conclusion

The decision whether or not to tell a child conceived by DI of his/her origins is embedded in a complex web of interests and policies that surround the practice. Traditionally, DI has been kept a secret by the medical profession which has sought to maintain donor anonymity primarily to protect donors, recipients and their children from harm. The use of donor anonymity and secrecy can be seen to shift from an initial focus on protecting the donor to protecting the social father, to protecting the child from knowing about his/her 'different' origins, to the need for disclosure to protect the child from lies and deceit.

Research on adoption that has documented the need to know one's genealogical background for the development of mature independence and a sense of identity, and the trend towards open adoption, have led to a belief that denying individuals conceived by DI access to knowledge about donor origins has increasingly become regarded as ethically unacceptable. International studies of the attitudes of recipient couples, however, reveal that the vast majority of parents still prefer not to tell their children that they were conceived by DI. Nevertheless, with some countries opting to legislate in favour of individuals having access to identifying information about donors, and growing public opinion in favour of 'openness', more couples appear to be in favour of telling their child about his/her donor conception. This is evident in



recent New Zealand research which indicates that over 80% of parents have told or plan to tell their children about their DI origins.

Most of the recipient couples participating in this study said that they had told, or planned to tell, their child of his/her origins. This reflects the current philosophy of New Zealand fertility clinics, which has been shaped by the ideology of the child's 'right' to know their genetic origins. This dominant discourse has been informed, not only by moves towards open adoption in New Zealand, but also reflects Maori beliefs about the significance of whakapapa, or knowing one's genetic heritage, which is an important consideration within New Zealand's bicultural context. In contrast to quantitative studies carried out by fertility clinics assessing recipient couples' attitudes to telling the child, this exploratory, qualitative study shows the complexities involved in the decision to tell or not to tell the child conceived by DI. Decisions about secrecy and disclosure are embedded in sets of social relations and professional practices, and therefore involve taking account of the interests of all significant parties concerned.

Couples responded differently to the issues emerging from the pressure to tell. Many couples were knowledgeable about theories of child development and chose to tell the story of their child's origins in incremental steps so the knowledge about their biological connection to an unknown donor, rather than to their social father, did not emerge as a shocking revelation. Many of these parents had used children's books on DI as a valuable tool for introducing the topic to their children; and others had written personalised stories of how their children were born. Other parents were unsure how, or when, to tell their child, or were waiting for the 'right' time to present itself. Most of those who were still waiting for the appropriate time to tell were parents of boys which raises the question of whether couples find it more difficult to tell boys than girls. Reluctance to tell boys may relate to claims that girls are more interested in where babies come from and therefore ask more questions about it. Equally, it may relate to concerns about the possible implications of the social father's male infertility for their sons who may consequently identify with or possibly reject their social fathers as inadequate. Certainly, several parents of boys claimed not to have given the matter of telling much thought, claimed ignorance about how to tell, or felt ill-equipped to answer the difficult questions that they envisaged would emerge as a

result of telling. Future research in this area might usefully explore possible differences in telling boys and girls about their donor conceptions.

For all the parents in this study, decisions about telling emerged as part of a process, or a 'journey'. Some decided to tell their child about their origins as soon as they were born. These were generally parents who went through a DI programme that actively encourages parents to tell children before they understand the concepts. This suggests that clinical practices have a bearing on whether, when and how information sharing with DI offspring begins. For others, the decision to disclose to the child emerged as the child grew older and in contrast to an original decision to keep it a secret. Many felt prompted to answer their child's initial questions about their origins; some parents said they were waiting for questions from their children about how they came into the world. Others sought to avoid the topic of donor conception until they thought it would be comprehensible to the child. Nonetheless, most said that they believed that they should not wait until the child was a teenager before telling him/her the truth.

Having told the children born after DI of their origins, the question still remains whether, like in adoption, many individuals would be interested in finding out more about their genetic father, or even contacting him. If, in fact, many do wish to make contact with the donor, the question also arises as to how many donors will in fact be available or willing to be identified many years after the act of donation. As one health professional interviewed for this research said, having donors who are potentially identifiable only, creates too much uncertainty to foster a desire to be 'open'. In her view, having a known donor is preferable to an anonymous donor because from the outset, "all the cards are laid on the table". But whether donors are known or not known, they still embody a third party in the procreative process which is something individuals conceived by DI will respond to in their own particular way. As Bok (1978:217) has pointed out, such responses will not be at all uniform. Most might be glad to know the truth about their biological origins, some would be indifferent, others might seek to meet and know their genetic father, and others might wish that the story of their conception could have been otherwise told.

## Chapter Ten

### Constructing and Locating Donors

We're probably increasingly curious [about the donor], aren't we? Compared to that initial stage [when] it was sort of helpful to have a certain distance between... you know, almost to think of him not a human being in a sense. *Alice, mother of a daughter conceived by DI.*

#### Introduction

Donor gametes make conception possible, but also construct a complex relationship between parents and the unknown, but potentially knowable, donors. This chapter explores how parents and kin of children conceived by donor insemination conceptualise donors. It examines attitudes, feelings and perceptions about donors, and whether or not recipients and their kin were curious to know more about donors, or even to meet them. Since donors are potentially identifiable in the future, the attitudes of parents and their kin towards their children possibly contacting donors are also a focus of attention.

Analysis of the interview material indicates that perceptions of donors varied among participants. This related to a number of factors including the perceived significance of biological and social ties, the perceived needs of the child, fear of the possible implications of children's contact with donors, and whether or not donors had indicated a willingness to be identified. Responses of parents and other family members to having an unknown stranger involved in the conception of their child were complex, ambivalent, and sometimes contradictory. For example, while many parents drew on the discourse of the child's 'right' to information about the donor, they professed to have little interest in the donor themselves and were more comfortable with the idea that donors remained anonymous. The challenges articulated by parents were in part an outcome of uncertainty about whether or not people conceived by DI will want information about donors or seek to contact them.

When explaining their perceptions and attitudes towards donors, couples and their family members drew on discourses of 'altruism', 'reciprocity' and 'gift-giving'.

Related to this discourse of giving was a discourse of gratitude. Drawing on the work of Simmel (1950), this chapter examines whether or not parents felt grateful to the donor and the reciprocal actions engendered by gratitude. Couples presented a broad spectrum of notions in their construction of the gifting act and these sometimes correlated with their reaction to the identifiability of donors. Some recipients had contacted donors anonymously via the clinics, sending letters or photographs of their children to express their thanks for their 'gift'. Discourses of 'science' and 'risk', and the relative importance of genetic and social ties, were also used frequently in talk about donors. A discourse of rights was also evident in recipients' and family members' talk about donors; in particular, the 'right' of the child to know his/her origins and potentially to meet the donor and, for some, the 'right' of the donor to identify his DI offspring. While many acknowledged the 'rights' of the child or the donor, many were also concerned about contact between them. These concerns were most significant among those who perceived such a meeting as a potential threat to social fathers (see Chapter Nine).

This chapter first examines professional discourses about the potential to identify donors, and fertility clinics' facilitation of anonymous exchanges between recipients and donors. The chapter then explores differences among parents in their attitudes towards donors. It identifies differences between those wishing to preserve anonymity and those wanting more information about donors, or tentatively open to contact. Finally, it examines the talk of those who would welcome the opportunity for contact with donors. Because of the complexity that emerges in participants' talk, a number of themes emerge that run across each category of this continuum. For example, women generally expressed more interest in donors and levels of interest in donors were related to the presence, or lack of the presence of, a social father and to marital status. Many parents and their kin were concerned about the risks of identifying genetic fathers.

### **The potential to identify donors: the intermediary's view**

As discussed in Chapter Five, the deliberate recruitment of anonymous sperm donors who are prepared to be identified to DI offspring in the future began in the late 1980s or early 1990s in New Zealand fertility clinics. Thus, the children born to potentially identifiable donors are still too young to seek contact. When asked if there had been

any instances of children conceived by DI meeting donors, one fertility clinic nurse said:

Nurse A: Not through our clinic, no, because the children are still quite young. The oldest are 10, I guess. So no, and then prior to that we didn't know who the donors were. So, no we haven't. It's an unknown quantity. It will be interesting to research in future years.

As discussed in Chapter Five, there is no centralised register of donors, recipients and their children in New Zealand, though pending legislation is expected to centralise and formalise the system.<sup>1</sup> Currently, individual clinics maintain their own records which should, in the future, enable individuals conceived by DI to identify their genetic father. Nurse A described the record-keeping procedures of one South Island DI programme:

Nurse A: All the donors are coded, and when a child is born we then send a copy of the donor profile to the recipient couple, so then the couple pass this information on to the child or children. So those children know who the donor is, or have a non-identifying profile of the donor. Because we don't know what's going to happen in the future, and there may be a central register which these donor children may access, and this is always discussed with potential donors, to make sure they're comfortable with that idea. So, if in the future, perhaps, a child was 18 or 20 and wanted to have information about the donor, or more information, they could come to the clinic. We would then contact the donor to see how he felt.

Nurse A indicated that the clinic staff would feel “very uncomfortable taking on a donor who didn’t want contact”, but she did not anticipate that all people conceived through DI will want to identify the donor. Donors are able to stipulate just how open they are to having contact with DI offspring and some are more willing to be contacted than others. A system is therefore in place to *potentially* allow individuals conceived by DI to make contact with their genetic fathers, preferably when they are young adults, but possibly sooner. However, because the children conceived through the current system are still quite young, the system has not been tested. The question thus arises as to how many people conceived by DI will be interested in identifying their genetic fathers in the future. This is the subject of some speculation and, because it is unknown, many health professionals and parents draw on the example of adopted people seeking their birth parents as a guide to the possible interest in contact with donors.<sup>2</sup> When asked if he anticipated that many children would want to meet their genetic fathers, the director of a DI programme said:

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<sup>1</sup> See Chapter Five for a discussion about the voluntary DI Family Register piloted by Fertility Associates, Wellington, New Zealand.

<sup>2</sup> For comparisons between adoption and DI, see Brandon and Warner (1977), Coffey (1987), Haimes (1988) and Midford (1993). According to Haimes, adoption might provide a useful precedent for DI,

Dr A: Well I don't know. I mean, nobody's really got any experience with that. One of the interesting things I always remember is that in Scotland, for many years, the child has had the right to know about their birth parents - adopted children. Very few are very interested in the male side of it. So, I mean it may be a curiosity thing and things like that. But I'm not sure it's quite as an emotional event for a lot of children, as there may be related to their mother who gave them up. If they know that this man made a present to help him or her exist, then that's different to "my mother couldn't look after me and had to give me up."

Dr A cited research evidence that pointed to the fact that, although adopted children in Scotland have had the information to enable them to search for their birth parents, very few had pursued this option.<sup>3</sup> He also implied that people are more interested in contacting their birth mothers than birth fathers, whose physical and emotional connection to them was perceived as more tenuous. The supposed lack of interest in identifying birth fathers, however, might be because it is more difficult to identify birth fathers, many of whom are not named on the child's birth certificate (Iwanek, 1998:29).

In the case of adoption, a decision was made by the birth mother (possibly in conjunction with the birth father) not to raise the child. In contrast, gamete donors choose to give a body product, not 'a child'; thus, it is argued, the connection between a donor and his DI offspring is even more tenuous. As a result, according to this argument, people conceived by DI are less likely to want to seek to identify the unknown donor, who is their genetic parent but not their 'father', especially because no social ties ever existed between the donor and the mother. This argument seems flawed, however, because many of the social ties that have resulted in the birth of a child subsequently placed for adoption have been little more than fleeting sexual encounters. In contrast, the planned and purposive act of donating semen to a DI programme indicates a social and moral interest in contributing to the birth of a child. Thus, it could be argued that the connection between the donor and the child is less tenuous because the conception occurred as a result of the donor's specified intent. Evidence from adoption research indicates that the circumstances of conception do

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but more in the way that it poses questions to be answered than as a source of solutions for direct application (1988:46).

<sup>3</sup> Humphrey and Humphrey (1986) cite research by Triseliotis (1973) which revealed that, over the previous decade, only 1.5 per 1000 adoptees over the age of 17 had made contact with the Registrar in Edinburgh to trace their birth parents. However, as the authors point out, the birth certificate information available to adoptees in Scotland was minimal and the task of actually finding the birth parents potentially formidable (Humphrey and Humphrey, 1986:134).

not necessarily have a bearing on adopted people's interest in knowing more about their genetic parents (Iwanek, 1997, 1998). Similarly, genetic ties alone may have some significance for some individuals conceived by DI, leading them to seek more information about their genetic fathers, even if they do not seek direct contact.

Counsellor A argued that while she thought people conceived by DI should have the *option* to be able to contact the donor, few would feel the emotional need to pursue this option.

Counsellor A: When I talk about choice of donors, I usually say, "I wouldn't touch anyone who doesn't have the box with future contact ticked." And now we don't have anyone who doesn't tick that box for future contact. So, I say, "That might sound a bit alarming to you now, but when you're looking at the rights of your child, when you're telling them the story about their origins, you can take it on yourself and say, well, we made sure they've kept the records for you and we've made sure that you can make contact in the future if you want it." My hunch is, and I usually say this too, is that the children won't have a driving desire. They're not looking for daddies, you know, they've got their father. I do a little bit of a blurb on the differences between adoption and DI. Some people are looking for identity, looking for the beginning of their story. The beginning of this child's story starts when [the parents] met.

Counsellor A's argument begs the question why adopted children often seek their birth mother or birth father when they already have a mother and a father. Counsellor A conceded that certain 'gaps' might be perceived to exist for the person conceived by DI, but that his/her motivation for seeking the donor would be different from those of adopted people. She said:

Counsellor A: Well, when you look at adopted kids who want to find their parents, it's for totally different reasons. They're looking for identity. They're looking to fill in the gaps in their story. Donor children might look for gifts, they might look for medical history, they might look for...they could be a concert pianist and you two could be tone deaf...and they might be curious about that. It would be curiosity. Not looking for, you know, that essence, and that identity, so much, that adopted children look for.

KH: So you don't think that identity is very closely related to genetics?

Counsellor A: Yes it is, but I think that having that social father there, that person that they've related to as their father. They've got a really close relationship from before birth, from conception. That gap has been filled to a considerable extent by that social father, not like adopted children so much, who came into the family maybe at three weeks, six weeks, whatever.

Counsellor A considered that the 'pieces' of knowledge individuals conceived by DI might be looking for were less substantial or emotionally significant than the more fundamental aspects of identity, related to the formation and severing of relationships, which adopted children typically seek. The assumption here is that the person conceived by DI will see the relationship with their social father beginning before

their birth and therefore not seek to fill 'gaps' in their emotional history. According to Triseliotis (2000:93), adopted people tracing their birth parents are generally looking for information about their genetic and genealogical heritage, explanations as to why they were placed for adoption, the physical appearance of members of the birth family, and the possibility for developing a new relationship (in addition to, not as a replacement for, the adoptive family). It is certainly possible to imagine that, apart from the explanations about why they were placed for adoption, people conceived by DI could potentially be interested in the same information that adopted people seek. The counsellor articulated the view of children's relationship to their fathers that is the dominant discourse at the clinic. The future adults conceived by DI are projected to have the emotional responses that are consistent with that discourse.

A scientist working in a DI programme reiterated Counsellor A's expectation that people conceived by DI would be less likely to want to seek their genetic fathers than those who were adopted. The scientist had this to say:

Scientist: It's an interesting question really. There may not be. Because they've got a biological mother who's their mother in every sense. They've got a complete family around them. They're never given up for adoption the way adopted children were. They were created in that family for that family, so there are some fairly big differences to the adopted children who have been keen to chase their birth mothers. But I gather not so many chase their birth fathers anyway. Though, by the same token, you do hear quite a few stories, often from the States about DI children who can't trace their origins and are very bitter about it. I certainly personally know one woman who was conceived by DI, she and her sister both were, and she's in her 30s now, and all she knows about her father is that he was a Scandinavian, and she'd love to know more, but there's no way she ever will, so that's sort of a permanent gap in her background.

The scientist acknowledged that some people conceived by DI were now speaking out about the bitterness they felt about this void created by a system based on secrecy.<sup>4</sup> What is unclear is whether they are bitter because they were deceived or because they cannot know anything about their genetic background. Research has shown that for some adoptees and DI offspring seeking the truth about their origins was the overriding concern, rather than attempting to meet biological relatives (Humphrey and Humphrey, 1986; Blyth, Crawshaw and Speirs, 1998). Participants in Turner and Coyle's (2000) study of the experiences of 18 donor offspring indicated that they were

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<sup>4</sup> For examples of accounts by adults who were conceived by DI of the difficulties that have arisen for them in connection with the lack of knowledge about their paternal biological origins, see the Donor Conception Support Group publication, *Let the Offspring Speak* (1997) and Blyth, Crawshaw and Speirs (1998).



negatively affected by the secrecy that had surrounded their donor conception, and were shocked when they discovered how they were conceived. Many reported that they needed to know their genetic origins and wished to search for their donors. Moreover, while these DI offspring did not experience being 'abandoned' as babies by their birth parents, many reported a sense of abandonment of responsibility by their genetic fathers and the medical profession (Turner and Coyle, 2000:2050).

The director of another DI programme was convinced that very few individuals conceived by DI would want to contact their genetic fathers. He explained his position:

Dr C: Well, first of all I would say, "What would *I* think?" And if I was brought up in a family and I know my mother's my mother and my father's my father. He's my old man, and I'm his mate...okay, my biological roots...I don't think I would want to know who my biological father is. I don't think so. But I mean, I may have a different view of that. I think it's different from the adoption process... So that's why I would suggest... I would be prepared to [bet on it] in a few years time. My bet would be less than 20% and I'm prepared to put \$100 on the table.

While Dr C was prepared to bet that less than one in five people conceived by DI would seek identifying information about the genetic father, uncertainty surrounds how much information DI offspring will want about donors, and how much interest they will have in them. Research carried out in New Zealand in the late 1980s indicated that donors were more likely to anticipate that DI offspring who knew how they were conceived would seek information about them than were recipients (Daniels, 1988:381). Daniels notes, however, that a large percentage of both donors (51%) and recipients (63%) thought that DI offspring 'possibly' would want information about the donor. Daniels' research, which was carried out before the passing of the Adult Adoption Information Act 1985,<sup>5</sup> showed that the majority of donors (59%) and recipients (47%) did not believe that people conceived by DI should be able to trace their origins. Twenty-four percent of donors and 44% of recipients were unsure, and 16% of donors and 9% of recipients thought it should be possible (Daniels, 1988:381).

If adoption statistics are any indicator, then it is possible that many people conceived by DI will seek identifying information about donors. According to Iwanek

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<sup>5</sup> The Act gives access to adopted people and birth parents about one another, while providing safeguards for those who want privacy (Rockel and Ryburn, 1988:59-60).

(1998:28), since the passing of the Adult Adoption Information Act 1985, “approximately 65 per cent of people adopted by strangers in New Zealand, or their birth parents, have obtained identifying information about each other”. Furthermore, she argues that research indicates that 95 per cent of these people have gone on to make personal contact, suggesting that most people sought contact if it was possible (Iwanek, 1998:28).

Given that donors recruited by New Zealand donor programmes are only *potentially* identifiable, the question also arises as to how interested donors might be in their DI offspring. As indicated in Chapter Five, fertility clinic staff have found that many donors are interested in the outcome of their donations. Recent research on donors has also shown that many are interested in knowing the outcome of their donations, including knowing about numbers of pregnancies and births and, in some cases, wanting to receive photographs of DI offspring (Daniels, 1998b:90).

Several parents of children conceived by DI said they wanted to express their thanks by writing anonymously to donors and sending them photographs of their children through the clinic, which acted as intermediary. Dr A said:

Dr A: We certainly have allowed parents to communicate messages of thanks to the donor through the third party. We've had women who've wanted to give a present to the donor, and we've passed it on. And I think that's nice, I mean I think it's [appropriate].

Dr A's views reinforce the construction of semen donation as a 'gift' that could elicit gratitude from recipients and the desire to thank the donor. To preserve anonymity, such transactions were carefully monitored by staff at the clinic. A nurse said:

Nurse B: After the child is born we have had people who have bought gifts for the donor, who have sent or brought in photographs, and those have been passed on, usually through [the scientist] who oversees it all. And she will ring the donor and say, “This is here, or that's there.” And some of them are quite chuffed and some of them... I don't know... I've only heard about the chuffed ones, but I've got a feeling that there might be one or two who perhaps weren't quite so keen, especially those who were around a good while ago.

Nurse B implied that donors who had been recruited at a time when recipients were given very little information about them, and who did not agree to be identified at any time in the future, were less likely to welcome any acknowledgement from recipients.

While there have been no reported incidents of donors and recipients with children conceived through DI meeting through the South Island fertility clinics included in this study, anecdotal evidence suggests that some donors and recipients have identified themselves to one another.

Nurse B: I know of one situation of a couple in Nelson I think it is, who sent a photograph of their donor child which was passed on to the donor, and the donor wrote back and they are now in direct contact. And this is sort of Christmas, so it's not a case of knocking on the door at the moment, it's a case of Christmas time and photographs.

While it is very much the exception, some meetings between donors and recipient families have been reported in the New Zealand media (Williamson, 1995).<sup>6</sup> A recent newspaper article told the story of the parents of a donor, who had died as the result of an accident, who gained access to their genetic grandchildren through the North Island clinic where their son had donated sperm (Dekker, 2000). Nevertheless, the arrangement of such meetings has been approached with extreme caution and, according to Williamson (1995:80), fertility clinics are wary of the “maze of spinoff issues” involved in ‘open’ DI. Thus, despite moves towards information-sharing between the parties to a DI conception in New Zealand, when the transaction begins with the anonymous donation of gametes, in general, maintaining anonymity remains a priority.

While the clinics will now only accept donors who agree to possible contact in the future, they suggest to parents that it is unlikely that children conceived using DI will want such contact. They also strive to preserve the anonymity of donors and parents.

### **Preserving anonymity**

Many recipients interviewed for this research were in favour of maintaining anonymity between the parties to the DI conception. They employed a variety of strategies for maintaining anonymity. Sandra, the mother of triplets said:

Sandra: We saw [the clinic nurse] a few times, and she asked us if they could let the donor know that he had donated eggs [sic] for triplets. And we agreed to that as long they waited six months because I didn't want him to be able to go to the newspaper and look back over the last few issues and find out who it was. We wanted to remain anonymous to him, I guess, yeah.

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<sup>6</sup> These reported meetings have occurred through North Island, rather than South Island, fertility clinics in New Zealand.

Their donor had not agreed to be identifiable at the time of donating, which was acceptable to Sandra and her husband Allan, who rationalised maintaining anonymity on the basis that their triplets would be more interested in being triplets than in “the business about their conception”.

Other parents employed distancing strategies that denied the donor any ‘ownership’ of their child. Tania, mother of a 9-month old son, had this to say about the donor:

Tania: I don't even think about him. Just, when I got pregnant. I just never looked at Levi as being somebody else's. I never ever thought about it. And the only reason I've got a copy of [the donor's] profile was because when I went in and took Levi in, she said to me "Oh, I'll give you one." I didn't ask for it, because it didn't really occur to me to take it.

KH: What about if you might want to know in the future? It might give you a better idea of his genetic inheritance on one side.

Tania: Yes. I don't know, because as I say I don't look at him as being anyone else's but Mark's, which is probably not right, but...

Tania was quite ambivalent about receiving the donor profile which provided tangible evidence of the existence of their sperm donor. Thinking that the child was her husband's illustrated that metaphor, as a cultural resource, is a mediator of disruption that enables people to recreate a sense of continuity and to reconnect themselves to the social and cultural ‘order’ after the disruption of infertility (Becker, 1994).

Although many parents were aware that their donor was potentially identifiable, and conceded that their child had the ‘right’ to make contact with the donor in the future, for many, this was a distant and almost unimaginable concept, and not a welcome prospect. Thus, some parents said they preferred not to think about the possibility of their children wanting to make contact with donors in the future. When asked how they would feel if their sons, currently aged between 3 ½ and 8 years, wanted to meet the donors, Joe and Ella said:

Joe: I think... I haven't really thought about it too much to be honest. It's not really something I particularly want to think about. I suppose, personally, I'll cross that bridge when we get there.

Ella: It's a long way away for us.

Joe: It is. It's got to be at least 10 years for the first one.

Ella: So, we don't really want to get...I mean, we're quite happy the way it is, but we're not going to stop them from contacting them.

Joe: No, if they want to, they're going to. And I suppose we're comfortable with that really. It's just something we have to accept.

Joe and Ella appeared to want to guard the boundaries of their nuclear family, and hoped that their children would not be interested in contacting their genetic fathers.

For some couples, the strong desire to maintain strict anonymity appeared to relate to on-going concerns about the donor possibly interfering in their child's upbringing. Clare and Simon, parents of a daughter, Maria, aged 9 years, who was conceived by DI, and two daughters aged 14 years and 7 years, who were related to them both genetically, were very concerned that the donor remain unknown to them. When asked if they were curious about the donor, Clare replied:

Clare: No. Definitely not. No. I mean, I'm grateful that he became a donor, but as far as I'm concerned, he was there for a purpose and that purpose was served. How we bring her up is up to us.

Clare implied that the donor might interfere if he was identified. She said of the possibility of her daughter wishing to make contact with the donor in the future:

Clare: Well, I think once she gets to that age, it's probably up to her. It is a reasonable concern to me that she will want to. At this point in time, I think she identifies so completely with Simon [her father], that it doesn't cross her mind, but when she gets to be of age, that's a bridge that we'll cross.

The likelihood of his daughter wanting to make contact with the donor in the future appeared remote to Simon. Clare's concerns in relation to the donor could be partly accounted for by their ambivalence about having had DI in the first place. Prior to having DI, they had had a daughter without medical assistance, but then experienced secondary infertility. A specialist had told them that they were unlikely to conceive again, unassisted, because of Simon's very low sperm count, so they opted for DI. Not long after Maria's birth, Clare conceived again without assistance which caused them to question the doctor's recommendation that they have DI.

Talk about donors illustrated the lack of adequate language to label donors and how to think and talk about them. When Steve and Jane were asked if they would like to meet their donor, they replied:

Steve: Well, no not really. I don't feel any need to rush out and go meet the man himself in particular. I don't know if there's been any approach, with people doing that in the past and there's been any problems with it.... I think that the information that's been given to us is sufficient as such that we do know that there are things about the donor. But to answer your question, no, I'm in no great rush to go out and see the person, but as you say, if it is through the children, and the children say well, "Where is my dad?" and if they do say after a period of time say, "Look hey, can we meet our dad?" well that's certainly something we've got to...

Jane: Not "dad". It's not actually really their father.

Steve: No, but in terms of the knowledge of the expression.

Jane: Genetic...it is...

Steve: Well, that's right, generic [sic] or whatever you like to call it, yeah.

While reticent about making contact with the donor himself, Steve acknowledged the need to respond to his children's potential desire or 'right' to know about the donor, whom he referred to as their 'dad'. Jane countered that he was not their 'dad' but their genetic parent, but Steve did not seem familiar with this terminology.<sup>7</sup> In keeping with Steve's framing of the donor as the children's 'dad', when asked if they felt grateful to the donor, Steve and Jane said:

Jane: I do, but I don't...

Steve: No.

Jane: ... not to the extent that I want to go and write to him and say thank you very much. No. I'm not that sort of person, I don't reckon. ...I don't think that Steve would want me to either, but, um, I don't know if that's sort of callous, or what, but I just...

Steve's denial of gratitude might be explained by Simmel's argument that "gratitude easily has a taste of bondage" (1950:393) which lies in the knowledge that the gift can never be returned. According to Simmel, "[g]ratitude is peculiarly irredeemable. It maintains its claim even after an equal or greater gift has been made" (1950:394). Steve might therefore wish to reject such a bond of obligation, just as some people refuse presents to avoid feeling they have to reciprocate (Simmel, 1950:393). Later, when Steve had left the room with the twins, Jane commented more freely on her views about sperm donors. She said:

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<sup>7</sup> Unlike Latin which has separate words for biological father (*genitor*) and 'social' or rearing father (*pater*), English has only the word 'father', which is generally understood as encompassing both biological/genetic and social fatherhood. Snowden, Mitchell and Snowden (1983) raise the issue of the need for an appropriate vocabulary to describe the roles of the persons involved in the assisted procreation of a child. They suggest "genetic father" as an appropriate term for the person who "provides and delivers the sperm for either internal or external fertilisation" (1983:35).

Jane: They're a very special person, because I don't even really know how I'd feel if Steve wanted to... if Steve was able to, if he wanted to do that, because I think it takes a very special person, and it takes a very special partner to let the husband do that as well. Yes, we are very grateful for that, because it must be the unknown thing for that family as well, and you sort of wonder, well, how are they? I don't really think about it, because I suppose we don't dwell on that topic, probably because, in some ways, Steve has different emotional feelings to me, so I don't talk about things that I'm more emotional about than he is, because of the difference in our outlook on life.

Jane was appreciative of people who donated sperm, and of their families, and had thought about the possible effects on them of having contributed genetic material to another unknown family. Her gratitude was therefore collective and safe, rather than focused on an individual donor. Jane's expression of gratitude for the existence of people who are prepared to donate their gametes to others illustrates Simmel's contention that "we do not thank somebody only for what he *does*: the feeling with which we often react to the mere existence of a person, must itself be designated as gratitude" (Simmel, 1950:389). Her comment that she and Steve did not talk about the donor links to discussion in previous chapters where wives subjugated their views to their husbands' emotions.

Most extended family members professed to have been told very little about the donor. Marion, the maternal grandmother of Diane and Chris's son, Scott, said that if she had been told anything about him, she had forgotten. She also claimed to have little curiosity about, and no desire to meet, the donor. When asked if the donor was ever discussed in relation to her grandson, Marion said:

Marion: No, not really. There might have been something very vague but certainly nothing that I recall, put it that way. But not, um, it's not because he's in hiding or anything, put it that way.

KH: But do you yourselves have any curiosity about the donor, or is he not in the picture at all?

Marion: No, he's not in the picture. Scott's colouring sort of ties in a bit with his mum's. I have at times wondered whether or not his colouring is coming from... oh, he tans a bit more, you know, from his... the donor, but, um, no, not a lot, because I just sort of see him... he's very much like his mum, I feel, to look at. But he's certainly starting to get a lot of Chris's mannerisms, and therefore, once again, it's a non-issue.

While Marion claimed that the donor was not a part of their lives, she nonetheless professed a vague curiosity about physical resemblance between Scott and the donor.<sup>8</sup> Her desire to recognise Chris as Scott's father is reflected in her relegation of the

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<sup>8</sup> The topic of physical resemblance and differences in families is discussed in Chapter Eleven.

donor's contribution to the status of a "non-issue". Similarly, an uncle of three DI nephews, suggested that the donor's contribution was "a chemical thing", while another uncle of a niece conceived by DI thought of it as a "gift from one family to another", which avoided focusing on the donor as a specific individual.

Other family members reflected on the difficulty of articulating and thinking about the connections between donors, recipients and their DI offspring and the implications for families of contact with donors. This indicated that not only parents, but also their kin have these concerns. Matthew and Julia, paternal uncle and aunt of Joe and Ella's three sons, appeared protective of Joe in his role as the boys' social father. In relation to the possibility that they wanted to contact their genetic fathers in the future, they said:

Julia: I don't think the problem's with the child. I think it's with the father, like Joe, that's actually brought the child up all their [lives]... it'd be like letting go of [their status as father]... It just depends on the person doesn't it? How secure the father is, and that was just my view that the mother is still the mother and she's the biological mother, and she can share with the biological father. And then the father, who's brought the child up all their life, if not out of the picture, doesn't fit in to the history of the child.

Matthew: The biological loop.

Julia and Matthew imagined that if one attended to the significance of biological ties the social father would be placed in a vulnerable position especially in relation to the mother who shared a biological link to the child with the donor. In contrast, if social parenting is privileged over biological connections then the donor becomes irrelevant, and the social father shares the social parenting role with the mother.

Offering another view, Frances, another aunt of Joe and Ella's three sons, who was adopted, contended that knowing some basic facts about their genetic fathers would be sufficient.

Frances: I think it's good if the children have got all the physical facts about their father. That's all the information that I've had, because I didn't meet my birth father because he died when he was 50, but I've got photos of him. And just to know the physical characteristics, you know, that to me is probably just as good. Just to see what they look like and a few statistics about him, and their hobbies and likes and dislikes and things like that.

KH: Yes, and that can be enough?

Frances: Yeah, it can actually.



Being satisfied with knowing only the basic “facts” about her birth father might relate to the fact that Frances knew she could never meet him. According to Humphrey and Humphrey (1986:134), research on adoptees who search for their birth parents has shown that those with a more satisfactory home life and positive self-image are more likely to be content with background information only. This casts doubt, they argue, on claims that ignorance about one’s forebears leads to personal insecurity. This research finding raises a number of issues. For example, it suggests that children’s desire to know and need to meet a genetic parent is then interpreted as ‘insecurity’ and this, in turn, may reflect critically on the parents.

Other researchers have argued, to the contrary, that adopted people who request information about their birth families in fact feel secure in their adoptive families (Kirk cited in Iwanek, 1997:17). Haimes and Timms (1985:75-76) are critical of what they describe as the psycho-pathological model that links the desire of adoptees to search for their birth parents with concepts such as ‘identity crisis’ or ‘deep psychological need’. In their study of adoptees applying for information about their birth parents, they found applicants were “normal, well-adjusted adults” who were assessed by counsellors as “naturally curious” rather than driven by a psycho-pathological condition (Haimes and Timms, 1985:76). Thus, they argue that adoption can be better understood in terms of a person’s *social* identity, rather than ego identity.

Some parents were not interested in identifying donors, but recognised the child’s potential interest in them. Andrew and Annie drew on the discourse of the ‘right’ or ‘need’ of the child to know their genetic origins. They were strongly motivated to keep records of the donors for their children’s information, and had compiled a folder of documents relating to their experience of DI. Andrew and Annie had this to say about the donor profile:

Annie: It was sufficient really. I mean it wasn't of interest. It is of more interest for the child.

Andrew: We can't expect to have photos, okay. What was written for Hayley was more than satisfactory. You can't identify the person, and I don't want the person identified to me through the donating process, because you'd see him in a crowd at some stage in the future.

New Zealand ain't that big. I don't walk around looking at everyone trying to work out whether they look like my daughters or not.

KH: No, so you're not really curious about the donor?

Andrew: No, not right now, no. This is the first time we've pulled [the donor profiles] out, and we've actually just put them in a folder so it's better...

Other parents acknowledged that their child(ren) might wish to make contact with donors in future years, but were ill at ease with the prospect. Richard and Belinda said that this was the most difficult aspect of having DI, and they initially had concerns about the donor's rights in relation to the child. They said:

Richard: I was actually very surprised at the information that was available [on the donor profile]. And thought it was very good. Um, I don't think about it as far as wanting to meet him goes, or probably even Madison wanting to meet him, but that's her decision in the end. But, um, I'm...to my knowledge he's been told that an offspring has been produced.

Belinda: I would like to write...what we can do through the clinic is write an anonymous letter, not identifying our names or anything...and we can actually write and thank the donor, and that's what I'd like to do. I want to thank this person, because it's given us a wee kiddie and great fun now. It's all fun and games in our house now. And, um, I'm like Richard, I'm not so keen to meet this person although, if Madison wishes to when she's a teenager, that's fine by me. I'll support her, but I just want to be open with Madison about it and let her know that we're her Mummy and Daddy, but the seed came from this particular man and it's up to her if she wants to find out.

While Richard and Belinda were grateful to their donor, their use of language in relation to him, such as “this man”, “this person”, and their daughter as “an offspring”, firmly positioned the donor as an outsider to their family, who existed only as the unknown provider of genetic material (“seed”)<sup>9</sup> so that they could have their ‘own’ child. In this way they marginalised and depersonalised the donor.

Richard and Belinda nonetheless stressed the importance of the donor's altruistic motivation to help an infertile couple, like themselves, have a ‘priceless’ child.<sup>10</sup>

Belinda: One thing that was really important to us was why he actually became a donor. And, this particular one that we have got now, his reason was his wife had infertility problems and they only actually conceived one child. And I thought, as a couple, that's a pretty nice thing to do, just go off and help others.

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<sup>9</sup> McWhinnie (1996:12) provides a script offered by one mother of a child conceived by DI who also referred to sperm as ‘seeds’ when answering her young child's question about where she came from.

<sup>10</sup> Zelizer (1985) argues that the 20<sup>th</sup> century has witnessed a profound cultural transformation in children's economic and sentimental value. In the earlier part of the century, children, who were once valued for their useful wage-earning capacities, became economically useless but emotionally priceless. Zelizer argues that, despite the financial costs of raising children in contemporary families, voluntary childbearing is an indicator of children's persistent emotional value to parents (1985:222).

Richard: He was loving enough really to say, "Well hey, I'm able to help somebody out," and that's what Belinda said before, the reason for some of these donors donating is actually very genuine, and not just a matter of saying, "Hey, I'm getting paid a hundred bucks for this," because they don't get paid for it at all.

Although they could not reciprocate to the donor, this couple actively supported a form of gift exchange by encouraging men they knew to become sperm donors and by Belinda approaching the clinic to become an anonymous egg donor. Belinda said:

Belinda: I want to help somebody else out, because to me, going through a pregnancy...oh it was great fun for us and having Richard there to actually watch Madison being born. I don't know who was more excited, him or me. Because he just kept saying, "God, look at all this!" (she laughs). It was just fascinating for Richard. Although I didn't get to see a great deal... he was seeing heaps and yeah, he was just so grateful for his little girl at the end of it all. I'd just like to help some other couple have that joy that we had. It was just so neat.

Belinda's desire to write to the donor and to donate eggs illustrates Simmel's contention that although gratitude may remain something purely internal, it nonetheless may lead to reciprocal actions (Simmel, 1950:388). Simmel (1950:387) argues that the sociological importance of gratitude "can hardly be overestimated" and that gratitude is the "moral memory of mankind" (1950:388). Gratitude, he maintains, plays an important role in the cohesion of society, because it establishes a bond of interaction and reciprocity between persons without it being guaranteed by external coercion. However, gratitude does not mean that direct connection is seen as appropriate. Although Belinda wanted to help another couple, as an egg donor she also wished to remain anonymous.

### **Hesitant contact**

While many parents said they were not interested in contact with donors, some maintained that their views on donors had changed over time, and they had become more accepting of the possibility of their children contacting donors in the future. Acknowledging the 'right' of their child to identify their donor, many of these parents drew on discourses of adoption and the possible risks and benefits to children of identifying their biological relatives. Initially, Henry, father of Jack, aged 8 years and Luke, aged 6 years, had been concerned that his sons might reject him in favour of their 'natural' fathers. He recalled:

Henry: It sort of bothered me. One of my concerns was that Jack or Luke, now they're people, get to their teens and become angst-ridden and go off and find their birth or natural fathers, and/or family, and there could be a swing of allegiances or whatever. It could be something to run to.

I've seen it happen in the foster situation, where the kids haven't come from a very good environment, and it takes them a while to work that out. Except we actually get given a certain amount of information about the donors, and they seem like good plain folk, and I'm quite comfortable about that now, but if the boys go off and find their parent or extended family... there shouldn't be any emotional hooks.

Henry explained his initial fears by drawing on discourses about children in other circumstances who did not live with their biological parents. This might be explained by Haimes and Timms' (1985:80) claim that because adoptees are not rooted in 'natural' relationships, there can be no certainty about with whom they might align themselves: to 'natural' or adoptive families or to no one at all. Henry appeared not to distinguish between fostering (where there could be two other 'birth parents') and DI (where the mother is the genetic/biological parent). His use of adoption terminology to describe the donors again raises the issue of the lack of appropriate language and frames of reference for conceptualising gamete donors and how they are positioned in relation to recipients and their children.

Henry's initial concerns about the possible threat presented by the existence of the donors, who might embody an attractive alternative father to himself (because the primacy of the biological tie is assumed), were allayed by two factors. First, his depiction of the donors as "good plain folk" suggested that they were "nothing special" and therefore unlikely to be preferred by his sons and, second, his friendship with a sperm donor. His friend Donald had become a donor after learning about the plight of Henry and Prue, and another couple who had children conceived by DI. Henry said:

Henry: I thought Donald was a help in his own way. He's quite eccentric, our mate Donald, but he gave us the other view. Now that's not supposed to happen, but he gave me the perspective from the man coming from the other side, and he told me all his hopes and fears and all those things, and why he did it. He's given me the whole thing. So it's not some spotty-faced university student getting his ten dollars by going in. That was a joke. It's a grown man making an altruistic decision, and okay, he's just a donor to some other families, but he gave me that view, and that was good...

There's a running joke about these massive little girls, because Donald's quite a heavy-built bloke with glasses, and we were having these jokes about these poor mothers around [an 'exclusive' suburb] shouldered with a daughter with glasses fluffing around in tutus at ballet lessons (he laughs). I keep saying to him, "I hope they don't grow up looking like you, you know (he laughs), if they're girls."

Having talked to Donald, Henry appeared to have developed some sort of understanding and acceptance of sperm donors and their role in the procreative

process. This raised the issue that anonymous donors are mysterious, not understood and therefore possibly to be feared. Henry anticipated that donors would be readily accessible to donor offspring in the future.

Henry: I don't think you'd have many donors who disappear. It's not like they're college boys like in the States, where they might just disappear. In New Zealand, donors belong to an altruistic network and the people will tend to run fairly tidy lives, I suppose. They won't just disappear. These are people who are part of society and there'll always be contacts with them surely. I think they're all men [as distinct from students]... the people we saw on file were mature people and they've gone through this process and they've thought it through and having talked to Donald, I feel as though they'll always be approachable through the system.

Henry appeared to have developed his views about the 'typical' donor from talking with his sperm-donor friend. His assumption that donors who provide sperm for 'altruistic' reasons are more likely to be identifiable in the future than those who 'donated' for pecuniary reasons relates to arguments against introducing the market economy into areas involving the sustenance or creation of life (i.e. blood, human organs and human gametes).<sup>11</sup>

Some parents who had received little information about their donor said that, although this had been of no great consequence at the time, in retrospect, they wished they had been told more. When Mary and Brendan had their son Jason, aged 12 years, they were not told anything about the donor. They received some written information about the donor when they had their second child, Natalie, aged 10 years. Brendan appeared more interested in the donors than Mary and said he would like to know "their side of the story". Mary was more circumspect and said about their two donors:

Mary: I didn't really think about them too much, because of the fact that I just thought about them being a person that wanted to help us out, and that was it, you know. I didn't put a face to what they'd look like. I just thought, well, this is a person that wants to help us, and they must be nice (she laughs briefly)... They've virtually forgotten what they've done really, I think. I don't know. Perhaps donors think somewhere there might be a child of mine walking around but I don't think that they really go into it thinking about that. They go into it because they want to help somebody and they don't really think too much about it.

Mary's perceptions of donors stemmed from the dominant discourses about DI and the role of donors at the time she conceived. Daniels (1998:78) cites comments from authors from the 1980s that suggests that donor semen should be regarded as 'material

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<sup>11</sup> For a discussion on the construction of semen donation as a 'gift', and the arguments related to the gifting and selling of human gametes, see Chapter Five.

from an anonymous testis' and the donor as a 'non-person'. Mary's perception of donors might also relate to the lack of information they had received about their donors. She claimed that Natalie's donor had written "maybe" on the donor profile in relation to possible contact with DI offspring. Brendan, however, appeared not to know this which suggested that this was not a topic of conversation between them. With respect to their daughter having contact with the donor, Mary favoured caution, whereas Brendan adopted a more laissez-faire position.

Mary: I think it would be more like her right if she wanted to.

Brendan: Yeah. I don't think that it would worry me. I mean... yeah.

Mary: It could complicate her life, you know. It could make it worse, or she might get something out of it. I don't know. It's very hard to say, because it's a bit like adoption. Some people...

Brendan: It's an individual thing, I think. You've got to leave it to them.

Mary: ...yeah...they really want to meet their birth mother, or they want to meet...sometimes it can benefit them, but in other times it can make their life more complicated and actually make them feel worse. So it's very much an individual thing, I think. It's a bit like, um, with Natalie, I know that there was another couple that had a half-sister to her and they did want... they asked me if I would be interested for Natalie to meet her. And the same sort of thing, I thought well this could complicate things, and do I really want this?

Mary conceptualised contact as a risky path. Her concerns relate to adoption discourses that frame the tracing of birth parents by adoptees as 'dangerous' or potentially 'vindictive' acts, and adoptees as not capable of coping with information that would enable them to straddle the biological-social divide (Haimes and Timms, 1985:80). As a result, Mary was not prepared to help facilitate a meeting between her daughter and the daughter of another couple who shared the same donor.<sup>12</sup> If Mary had agreed to allow her daughter to meet her 'half-sibling', it would perhaps have indicated the importance of 'blood' ties and genetic connection, rather than social parenthood and family location. As discussed in Chapter Five, Mary's reluctance to facilitate a meeting might also have related to the lack of a 'script' about how to frame the relationships. Brendan claimed not to know that another family, who had used the same donor, had sought contact with their daughter which implied that Mary had made the decision not to have contact.

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<sup>12</sup> For a discussion about the facilitation of contact between families who have conceived children using the same donor, see Chapter Five.

Some parents had given considerable thought to the possible significance to their children of identifying their genetic fathers. Stephanie, mother of three children conceived by DI, said that she and her husband had received minimal information about the donor when they conceived their oldest son, Liam, aged 12 years, and were unable to find out more. She said of Liam's response to this:

Stephanie: Liam said, "look if I walk down [the street] naked with a chook on my head, it's not going to change anything, so why be stressed about it?" And so, that is his attitude at the moment. But, inevitably he'll feel some twinges if Marcus and Louise choose to meet their donor. But it's interesting, I doubt that it will be so important to Marcus. Liam's a details man, everything's got to be in its right place, whereas Marcus is a dreamer....

I've done some reading about relinquishment, and that was another theory postulated that donor children didn't want to know or hadn't had the tendency to want to know so much because they had no sense of relinquishment. They'd never actually been handed over. I mean, relinquishing genes, or sperm or gametes is not quite the same as relinquishing *them* specifically. But I think...it wouldn't surprise me if the kids were just 'interested'. And if I wanted to meet the donor and say, "Thank you, you've brought great joy to our lives," that's the only other reason, just "Oh, I wonder what he's like." And that's all.

Stephanie anticipated that her children might be interested in their genetic fathers to some (unknown) extent but had read that unlike adopted children who were 'relinquished' after birth, children conceived by DI were less likely to be interested in their genetic parent.<sup>13</sup> Her expectation that they might just be 'interested' suggested that, like adopted people, individuals conceived by DI might also have a 'natural' curiosity to see what their genetic fathers were like (Haimes and Timms, 1985:76).

Other parents speculated as to whether the donor might be interested in contacting their DI offspring. Diane, mother of Scott, aged 3 years, said:

Diane: I think if he wanted to, he should be able to, because they are still his biological children. I don't know whether he would. He's been a donor there for a little while and he has a couple of children through the clinic, so I don't know whether he would, from what I've picked up about him through the clinic.

Diane and her husband, Chris, were also uncertain whether their son would want to meet the donor.

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<sup>13</sup> Although distinctions are often made between adoption and DI on the basis that in DI, unlike adoption, the child was not relinquished, Midford (1993:6) argues that relinquishment can be compared to the donation of human gametes in important ways. For example, donors relinquish the potential of a

Diane: If Scott wanted to, I certainly wouldn't feel threatened, or, um, really that he's going to be looking for his 'real' father, like with the adoption issues. I've got no feelings like that at all. If he wants to see him, it's fine.... I know there's a strong thing with children that they do want to find their roots and whatever, so, but, as I say, he will be able to.

Chris: But then again, by the time he's a teenager... it could happen...but I mean that's just a sign of the cycle that we're going through. We've become very liberal and all this airy-fairy type stuff, and you know, finding your roots and all this. I mean it's a buzz-word of today that'll probably be gone by the time he's a teenager. Who knows, but, you know...

Diane: He could still have an interest in his other parent.

Chris: Yeah. But I don't think there's a big difference between that and adoption.

Diane: There are a few little similarities.

Chris: And I mean, if he wants to, that's fine. That's his call really. And I mean that's just... you know we went through it with the egg donor.<sup>14</sup> I mean, these things, you can sit around and hop onto a spiral, and talk about the ifs and buts and whens, and really it's just about managing it when it arises.

Chris asserted that discourses such as the need to 'find one's roots' were socially constructed and not an outcome of intrinsic human needs. Triseliotis (2000:93) maintains that the search for roots was one of the main characteristics of the 1970s, 1980s and 1990s, made respectable by minorities wanting to assert ethnic identities and adopted people wanting to establish more complete selves. Nevertheless, Diane conceptualised their donor as her son's "other parent" and, because of the genetic connection between them, envisaged the possibility of either the donor, or her son, being interested in meeting.

Diane claimed that if she thought about the donor at all, it was usually in connection with her gratitude to him.

Diane: I can honestly say that the only time I think about his biological origins is to thank whoever that he's here, you know, and to be really grateful to the donor that we had him. That's the only reason I think about it, and I do that frequently, you know.

Diane and Chris's experience with having an anonymous sperm donor contrasted with their experience as recipients of donated oocytes. In a bid to have a sibling for Scott, they were embarking on a treatment cycle that involved both egg and sperm donation.

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human life from their genetic heritage and give up their rights and responsibilities as parents of the child.

<sup>14</sup> Diane and Chris were about to embark on an IVF cycle, which would involve the use of donated eggs and sperm, because Diane was 'premenopausal' and was considered unlikely to conceive using



Diane and Chris had met the egg donor through a North Island egg donor programme which facilitated meetings between egg donors and recipients. They said:

Diane: We haven't of course met the sperm donor. I've actually met the egg donor and I felt a lot better after having actually met her. Not better, not that I had any reservations, but I was really happy to meet her. It was a really nice thing to do. And we'll keep in contact with her through the clinic.

KH: There do seem to be differences there in that often egg donors do meet up with recipients, whereas...

Diane: It's what a woman wants to do.

Chris: They're females (he laughs).

Diane: Yeah. Yeah. That's true. It was quite interesting when it came to choosing, like the sperm donor... the information that they give you is very brief and to the point, whereas the egg donors were very... a lot more expansive, weren't they? They were completely different.

Diane and Chris thus raised issues about the gendered features of responses of donors and the different processes involved in donating sperm and donating eggs.

Haimes (1993a) examines the ways in which gender is deployed to construct meanings about semen and oocyte donation. According to her analysis, semen donation was associated with negative connotations of adultery, masturbation and illegitimacy. Moreover, semen donors were regarded as strangers with questionable motivations and semen donation was regarded as unregulated and undesirable, and its very simplicity (and the potential for sexual pleasure) a danger. In contrast, the risky, physically invasive and uncomfortable or even painful act of egg donation was seen as reassuring. The clinical and familial context of egg donation provided a sense of regulation and control and the egg donor was seen as less of a threat because her claim to genetic parenthood was offset by the claim of the carrying mother to biological motherhood.<sup>15</sup> Haimes' examination of the Warnock Committee Report (1984) revealed donor anonymity was regarded as necessary to avoid unwanted

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her own ova. They had therefore discussed with the egg donor the possibility of the potential child wanting to meet her in the future.

<sup>15</sup> In New Zealand, Section 9 (a) of the Status of Children Amendment Act 1987, states that where a woman becomes pregnant as a result of a donor ovum or donor embryo implantation procedure, the woman shall, for all purposes be the mother of any child of the pregnancy.

intrusion from donors in recipient families. In contrast, egg donors were expected to be part of the family and to be donating for altruistic reasons.<sup>16</sup>

While ambivalent about contact with donors, some parents indicated that they would actively support their children in meeting donors in the future. Patrick, who identified as Maori, and Helen, a pakeha, had a Maori donor whose sperm had been sourced from a North Island clinic. They said about their donor:

Helen: Oh, it had to be a Maori donor. And it had to be someone who could be approached. It wasn't to be a hidden thing. When your children ask you questions, you've got to be able to be honest with them. That was important to us.

KH: How do you feel about him being up in the North Island?

Helen: We're glad about that, I am, I'm glad about that. He can stay there as far as I'm concerned. I don't know what you [Patrick] think, but I think he can stay as far away as possible, and that gives me at least 15 more years to prepare myself for the day that I'll have to help my children, if they decide, okay, we want to see this guy, we want to have a look at him. Because I'd definitely support them if they wanted to do that. I wouldn't see it as a slap back to us. I'd see it as a positive thing.

Patrick: This is what we discussed the first time round, before we even went ahead with it. We didn't want to know him, but we would help the children. Since then, nothing has changed. It's still the same.

When asked if they thought their sons would be interested in meeting the donor, they said:

Patrick: I'm sure they will be. It's part of human nature to have that curiosity.

Helen: Yeah. And if you look at the Maori side of things, whakapapa is very important, very important. Patrick can talk about his family going back, but he wished he knew more. We have also thought that if they find out more about the donor's background, they could find that Patrick and the donor may even come from the same tribe, or be related.

Patrick thought that 'essentially' human beings were curious about their genetic origins which reflects Euro-American kinship ideology about the importance of 'blood ties', but also the significance attached to genealogy in Maori culture.

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<sup>16</sup> A study of issues in non-anonymous oocyte donation indicated that although 94% of donors reported altruism as their primary motivation to donate, interviews revealed a more complex picture (Bartlett, 1991). Egg donation was regarded by some as "making up" for having had a previous abortion. Moreover, half the egg donors reported feeling "flattered" by being asked to donate genetic material to an infertile couple (Bartlett, 1991). This raises the issue of the possible coercion of egg donors. According to one study, rather than being overt, coercion was more likely to occur through the widespread societal objectification of women and their bodies and their characterisation as selfless, caring, self-sacrificing and altruistic (deLacey, 1995b). Arguments about coercion, however, tend to

According to Helen, they had speculated about a biological or tribal connection existing between the donor and their family which would make it even more appropriate that their sons should meet the donor. Helen, however, was also somewhat ambivalent about the prospect of such a meeting. She said:

Helen: In saying that, with the donor, I really hope, and it worries me a little, that over the next 10-15 years he doesn't do anything stupid, you know. I don't want my kids to meet up with him and come home and say, "Hey, I saw him on Crimewatch," you know, or something like that. And it does worry me. It worries me that meeting him and his family could be a terrible culture shock. We don't have hangis and all the neighbours around, and have sleepovers for a week, do we? We don't talk about that.

KH: Do you do any traditional Maori things?

Patrick: No.

Helen: We don't.

KH: You live a pakeha kind of life?

Helen: Very, very. But they know who they are, and like we're trying to give them some of their culture [they have Maori words labelling objects around the house]. We're not going to deny them that, but we don't see the need to show them that there's that, what's that movie, 'Once were Warriors'<sup>17</sup> side, it could be there. But we don't want them to see that.

Helen's ambivalence about having a Maori donor arose out of her ambivalence about Maori culture. While Helen wanted a donor of the same ethnic background as her husband, and recognised the importance of certain cultural understandings, such as *whakapapa*,<sup>18</sup> she also feared that her children's genetic father might break the law.<sup>19</sup> She was also concerned about a possible cultural gap between her children and their genetic father because of their lack of familiarity with some aspects of Maori culture.

While ambivalent about being able to identify their donor in the future, Helen was nonetheless very grateful for his 'gift'. When she was pregnant with Thomas, Helen and Patrick often referred to the donor by a special name (which they said they could no longer recall, but had to do with him being a generous person). Helen said:

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disregard the agency of gamete donors who, whether they are male or female, may choose to become donors for a variety of complex reasons.

<sup>17</sup> *Once Were Warriors* (Duff, 1994) is a controversial New Zealand film that depicts domestic violence within an urban Maori family.

<sup>18</sup> According to the Ministry of Justice (2001), "[w]hakapapa is central to Maori society. Whakapapa defines both the individual and kin groups, and governs relationships between them. Whakapapa confirms an individual's membership within the kin groups that constitute Maori society and provides the means for learning about the history of their tipuna (ancestors)".

Helen: But it is a gift. It is the gift of life. It's a special gift when someone gives a part of themselves, whether it be their heart, or their eyes or whatever... Anybody who can give somebody life like that must be a special person.

As a means of expressing her gratitude to the donor, like Belinda, Helen had wanted to reciprocate by anonymously donating eggs to an infertile couple. She said:

Helen: I have offered to donate eggs anonymously, but they said no, people have to bring their own egg donor. But I just thought it would be much easier for a woman if she didn't have to see that face, if she didn't have to go to the shop and bump into that woman (she laughs).

Helen appeared to be projecting her own desires for the donor to remain anonymous (at least while her children were young) onto how a woman who received donated eggs might feel. In her study of egg donors, however, DeLacey (1995b) is critical of anonymous egg donation on the basis that it is recipient-centred and positions donors as a potential threat to the nuclear family. In her view, egg donors appear to benefit more from known donation practices where information exchange is unhindered. This, in turn, reflects research that indicates that birth mothers benefit from open adoption arrangements (Berry, 1991).

### **Incorporating donors**

Several parents envisaged the possibility of incorporating donors into their lives at some time in the future if this was perceived to be beneficial to their children. Neil and Patricia had this to say about their donor:

Neil: Well, I would be quite happy to meet him. I wouldn't... the only thing, I wouldn't be interested necessarily to meet him other than through my daughters' interest in meeting him.

Patricia: I've felt the same. I was about to say that, for any other reason I wouldn't have met him, so I don't really want to meet him for any reason really, apart from the fact that [the children] might be wanting to meet the donor and want me to meet him, and from that aspect I would.

These parents had initiated contact with the donor anonymously through the fertility clinic, to thank him for his 'gift', but also as a strategy for ensuring that he would be identifiable at a later date if their children wished to make contact. Neil had a

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<sup>19</sup> Helen's concerns relate to Maori being over-represented among offenders in New Zealand. According to New Zealand statistics, the incidence of offending and incarceration is higher among Maori than pakeha/European or other ethnic groups (Statistics New Zealand, 1996:34; Lash, 1998:24).

particular interest in this because he was adopted and, as a result of having children by DI, had recently sought contact with his birth parents.<sup>20</sup> He said:

Neil: We actually wrote a letter to the donor. So we got more information, and it was really great to get an encouraging and positive letter. Our letter was to say that we wanted to check out his preparedness to have contact at some time in the future, should Tracey wish that when she was older.

KH: And what sort of response did you get from him?

Neil: Very positive. He was happy to.

Neil had also written to the donor after the birth of their second daughter, though he had not yet passed the letter on through the clinic. His reasons for writing were:

Neil: Well, just to let him know of our thanks again for his gift, and to let him know that we were thinking about how he'd helped... Well, just to give him basically a bit of an update on what sorts of interests Tracey had, and how she was growing up, and just to reiterate that one day if the children wanted to make contact... just make sure that was still...[a possibility].

Neil and Patricia said that they planned to provide occasional 'updates' on their daughters' lives to the donor, as a way of facilitating their eventual meeting, should their daughters initiate it. Parents' actions to ensure that their children conceived by DI have access to knowledge about their genetic heritage from the donor highlights their belief that such information might be significant for them. It also brings into stark relief the uncertainty surrounding the possibility of future contact between people conceived by DI and donors in a system where, at the point of donating their gametes, donors agree to be identifiable at a later date, but cannot be held accountable.

Other parents said they hoped that their donor would be available to meet their child if they had particular problems associated with having been conceived by DI. Pippa, mother of Elspeth, aged 19 months, said about the donor:

Pippa: And he says he's identifiable, so hopefully if she needs to... they said she can contact him at 18. He hasn't got any children of his own. He's in a de facto relationship. So, she can meet him at 18, and hopefully if she has problems earlier, he would be prepared to meet her sooner.

KH: Identity problems?

Pippa: Yes. If Elspeth was having problems, I'd like to meet him first with Sean [her father], and his partner, and then maybe we'd all meet later... I think we can make contact if there's a problem.

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<sup>20</sup> See Chapter Three for a discussion of the meanings Neil attached to biological and social ties.

I think if Elspeth was having real issues with it, because I know somebody else from the donor programme whose son is about nine and finding it very difficult, which is unusual, because most boys don't seem to apparently, it's more the girls. And they were contacting the donor, so he could meet him.

Like Neil and Patricia, Pippa had contacted the donor anonymously through the clinic.

Pippa: I sent a letter to the donor with a photo of Elspeth. Apparently he was delighted. Yeah, they were really, really pleased. I chose a photo of her that he wouldn't recognise now, because I don't want her recognised on the street. So, now, I've sent him one of quite a few months ago, so he wouldn't recognise her from that.

By sending photos of her baby that were several months old, Pippa engaged in nuanced communication: she wanted to show the donor the child, but not in a way that she could be identified by him. This contrasted with her expectation that Elspeth might wish or 'need' to meet him in the future, and illustrates the ambivalence of a number of parents about their relationship to donors of sperm. A number sought contact, but also valued anonymity until these children were old enough to state their own desires about possible face-to-face contact.

Elspeth's paternal grandmother was fearful of her granddaughter possibly meeting the donor in the future. She said:

Joan: I'm scared of it. I don't really like it, for my sake, but for her sake it's right that she should, because I think it's very important to know about your grandparents and your great-grandparents. So, she should. It wouldn't be fair that she didn't. But when I think that, then I think that maybe Sean will get his nose pushed out. So I fear for him.... But I hope Elspeth will be proud of [the donor] and love him and be glad that that person is her father, because I think it's important to people if they can be proud of their parents, don't you?<sup>21</sup>

Joan illustrated the tension between different sets of rights. She juggled a variety of contradictory discursive frames in relation to the parties involved in the donor conception arrangement. She thought that the donor, as her granddaughter's genetic parent, should be acknowledged, and that in all fairness the child had the 'right' to know, not only her biological origins, but the donor himself, whom she hoped her granddaughter would love and be proud of, as one should one's parents. At the same time, she feared that her son, as the social father, would become an 'outsider' if his daughter formed a relationship with her genetic father. For his sake and her own sake,

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<sup>21</sup> As discussed in Chapter Three, Joan said that she could not feel proud of her granddaughter because she was not biologically tied to her and therefore had nothing to do with who she was. Pride in one's offspring was therefore, for her, the outcome of biological rather than social ties.

she therefore did not like to contemplate a meeting between Elspeth and the donor, whom she referred to as Elspeth's "father". Joan commented later that she hoped such a meeting would happen after her death, so it would not affect her.

Ria and Sophie, a lesbian couple who chose a known donor, stressed the importance of children being able to identify their biological parents. Ria said:

Ria: I think it's important for the child, because I myself was adopted and I've met my birth mother and she said that she wouldn't help me find my birth father and wouldn't go into it.

KH: Did you find that quite disturbing or unhelpful?

Ria: Um, just unhelpful really.

KH: Do you want to know who he is?

Ria: No, I don't really have a great interest.

Sophie: I think the health history would be interesting more than anything.

KH: Not for your sense of who you are?

Ria: No. Well...

KH: Wouldn't you be curious to know his family background?

Ria: Yeah, yeah. I mean, I do occasionally get curious, but after having gone through the difficult line of trying to find my birth mother, and I guess having expectations and it not working out to be what I expected, I don't want to go through that again. So, yeah, I guess there is that curiousness of what he looks like and whatever. It's really important for me that my child can have the choice to know where he or she came from.

Ria's inability to locate her birth father supports Iwanek's (1998:29) contention that because birth fathers are often not named on the birth certificates of adopted people, they are dependent on birth mothers for information. This might not be forthcoming if the birth mother still felt hurt or betrayed, or simply had put it in the past. Ria appeared to have some curiosity about her birth father, particularly in terms of knowing what he looked like, but her inability to locate him did not appear to be detrimental to her sense of identity. Triseliotis (2000:93) suggests that many adopted people tracing their birth parents are interested in the physical appearance of members of their birth family which, he claims, relates to the issue of physical identity.<sup>22</sup>

Ria's partner, Sophie, suggested that knowing the birth father's medical history was perhaps of more interest than knowing him as a person. This relates to O'Donovan's

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<sup>22</sup> For a discussion of the significance of family resemblance see Chapter Eleven.

(1989) argument that the emphasis in the adoption literature on the psychological need to ‘search for origins’ overlooks the practical reasons, such as medical and genetic history. Some extended family members of children also suggested that knowing the health and medical history of the donor was perhaps the most relevant type of information to be shared with DI offspring. In these cases, the connection between the donor and the DI offspring is justified medically rather than socially.

Some parents of children conceived with the help of an anonymous sperm donor, thought that it might be helpful for the child’s sense of self to possibly meet him. Peter and Alice said that their perceptions of the donor had changed since they initially selected him from a donor profile, which illustrates that donors’ identities shift over time. Alice said:

Alice: We’re probably increasingly curious, aren’t we? Compared to that initial stage - it was sort of helpful to have a certain distance between...you know, almost to think of him not a human being in a sense, more the donated kind of...

Peter and Alice had chosen a donor who had indicated on his profile that he was willing to meet any DI offspring “sooner rather than later”. They said:

Alice: We’ve thought about actually at some point maybe meeting him, earlier rather than later, so that we could get a photo, and we can talk about him to her, and then at some stage, when she’s older, if she wants to make more contact, then she could do that... so that it’s not a secret and it’s there and so the curiosity I think will be... then it’ll be up to her what she does with it.

Peter: Yeah. The timing is pretty important because it would be really good if we could sort of normalise the information by just having a relationship with his family... even if it’s just the occasional sort of acquaintance level... because we have heard of other donor children who’ve found it more upsetting to find... to realise that they’re different, than it is to kind of know about it... and sort of having an occasion when you’re gonna have to meet people because they have some importance to their lives.

Peter indicated that meeting the donor would obviate the potential ‘need’ for Erica to later ‘search for her genetic origins’. Alice and Peter wondered if they might be the first couple to initiate contact with the donor through the clinic they had attended. However, they also acknowledged that it was difficult to know if this was the right course of action. In many ways, they said, it was easier to be complacent, to forget about it and just get on with their life.

The maternal grandmother of Peter and Alice’s daughter explained her views on the possibility of Erica meeting her genetic father:



Janine: The thing is, as long as she knows that Peter is not her biological father, as she grows up, she'll probably have a natural curiosity to meet the man or to, you know, I would think, I mean, that seems to me to be quite normal. And I'm sure that with the guidance of Alice and Peter that it won't become an issue. I think she might meet him, but I don't think it'll affect her love for Peter.... And there was no relationship between Alice and the man, or anything like that... so... but I still think that she might want to actually see him, as you say, out of curiosity, to see what he's like.

Janine drew on an adoption discourse about the 'natural curiosity' to meet one's biological parents (Haimes and Timms, 1985:76). She did not envisage that this would interfere with Erica's love for her father, Peter, especially because there had been no relationship between her mother and the donor. This has to be articulated because 'usually' the connection of the sperm and the egg involves 'a connection' between people. What is usual, needs to be articulated and distinguished from what happens in DI.

In contrast to Janine's views about Erica possibly meeting the donor, Peter's father, Jim, drew on an old adoption discourse about the 'dangers' of crossing the boundaries between the biological and the social (Haimes and Timms, 1985:80; Haimes, 1988:55). He said:

Jim: I think I said to Peter, "Don't you think that's adding sort of another risk dimension to the whole thing?" Peter and I can always have an argument on something, so I think it was stopped fairly quickly (he laughs). He's got a mind of his own. No, I wouldn't interfere. That's their business really, and, ah... My own impression is I don't know whether it would do a lot of good, but ah... it's up to them.... I can accept [children conceived by DI] being told, but I don't think that it's altogether necessary for them to meet another man who's the biological father. As I say, it's adding another risk factor to the whole thing, which... there may not be any risk, but it's all confidential in the early stages, why not leave it like that? There are safeguards there.

In connection with the prospect of his granddaughter meeting the donor, Jim repeatedly used the language of 'risk'. Jim's concerns about the choices that his son might make in relation to meeting the donor relate to arguments which posit that, in late modernity, agents have become less constrained by institutional structures (Petersen, 1997). In these conditions, individuals must become the masters of their own fate, bearing the consequences of their own decisions as they participate in the individualisation of risk (Beck, 1992, 1999). Alice and Peter thus construct themselves as individual autonomous and risk-bearing actors as they embark on contact with the sperm donor.

Jim's acceptance that his granddaughter should know about her origins, but not actually meet her genetic father, raises one of the thorny issues and paradoxes that exist in the way that DI is organised. Haines raises the issue of the difficulty of 'telling' within adoptive families when the prescription to be 'open' comes from sources that promote institutional secrecy (1988:55). Similarly, in the case of DI, clinics advocate that children should be told of their origins, while their institutional structures revolve around anonymity, albeit with the expectation that donors are potentially identifiable at some later date. Difficulties thus arise for parents who tell, but are then asked by the child for information about the donor which they cannot provide.<sup>23</sup>

Some mothers had sought to make contact with the donor, while their husbands argued for the need to respect donors' privacy. One couple who had DI through a North Island clinic had written to thank the donor, and identified themselves. Sarah said:

Sarah: When [Charlotte] was six months old we wrote to him via the clinic to say thank you very much and that we were absolutely thrilled. We gave him all her details - date of birth, and name and ours. He knows where we are. ... And we just said that if he would ever like a photo of her, or to meet with her or us, that we would welcome it, and that if he didn't that we would respect his privacy. Actually we wrote the letter to him and his wife, because he was married with two children, and I guess she would have been a part... because their information was on the whole profile, we just assumed that she was part of the whole decision.

We didn't hear back, but I was worried that the clinic hadn't passed it on. And, so they checked for us, and he had received it, and he was really thrilled to receive it and know that we were happy. And thanks very much, and we'd leave it at that. But another day could come and this person could knock on the door, and he'll be there, and I'll know who he'll be.

KH: And that wouldn't bother you?

Sarah: Not at all, I look forward to it.

The lack of a direct response from the donor illustrated how gamete donation is primarily constructed as an anonymous transaction to enable an infertile couple to have a child, and thereby create their 'own' family. It also highlights the way in which anonymous gamete donation is set up to preserve the privacy of the nuclear family,

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<sup>23</sup> In December 1997, the Christchurch Infertility Society received an anonymous letter from a mother of two children conceived by DI, who described her frustrations about 'telling' in the context of not being able to answer her daughter's questions about the donor. Her 9-year-old daughter had asked the donor's name, wanted to know whether the donor's father could be a replacement for her dead grandfather, had asked for a photograph of the donor, and so on. This mother urged that DI become organised along the lines of open adoption.

and reinforce the notion that crossing those boundaries might have negative consequences for the families involved. Concerns about donors 'intruding' into recipient families relate to arguments espoused by proponents of anonymity between the parties to a donor conception. Such arguments posit that anonymity enables the recipient couple to construct their own parental status without feeling indebted to a known donor, and that it also protects the child from what is construed as a potentially harmful multiple parent situation (Raoul-Duval et al, 1992).

Through open adoption, Sarah and Tim had on-going contact with their adopted children's birth mothers, and their foster daughter's biological parents are their friends. Sarah, however, appeared reluctant to tell her adopted children about their birth fathers. She claimed that it was easier to talk about the relationship with birth mothers by describing to her children how they grew in their birth mother's 'tummy'. In contrast, her children's birth fathers were distant, marginalised figures with whom they had had almost no contact. Rob's birth father had not seen him since he was two years old, and was no longer in a relationship with his birth mother. Sarah's sister, Phoebe's birth mother, claimed not to know who her birth father was, so he could not be identified. By not introducing her children to the concepts of birth fathers and donors, Sarah appeared, at least in part, to be protecting Tim and his relationship with their children. Thus, her decision to identify themselves to the donor appeared somewhat contradictory.

While Sarah appeared open to the donor arriving on their doorstep, Tim was less enthusiastic about the prospect of such a meeting. He said of the donor:

Tim: I would respect his privacy. If he ever requested to meet his donor daughter... I think he's the parent of a few... he's been successful a few times. Yeah, but it's not like I'd really like to meet this guy. I mean, what he's done is really great, and he's had his own family, and maybe he... I don't know... for whatever reason he's done it, you know, which is great. Like, Charlotte is just a real little cracker. She's beautiful... a beautiful child.

While Tim indicated that the donor had the 'right' to contact his biological offspring, it appeared that the letter identifying them to the donor and saying that they would welcome contact, was initiated by Sarah, rather than Tim.<sup>24</sup> As well as writing to the

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<sup>24</sup> Tim did not stay for the entire interview. While forthcoming, he nonetheless appeared ambivalent about being interviewed. Perhaps partly because some of his views were at odds with Sarah's, he asked me to ask him questions, excused himself and went outside to attend to the children.

donor to express her gratitude, Sarah also had a strong desire to donate her eggs to another infertile couple. She said:

Sarah: I've always said I'm going to donate eggs as well, to give something back to the programme. Tim's actually really not all that keen on it. And he says, "Well why do you want to do it?" and I say, "Well, you know, it's something I thought I would do when we had Charlotte," you know, and he says, "Well, you don't have to do the eggs, you're doing enough. Are you doing it for egotistical reasons? Do you want to say you've got another child out there or something?" I said, "Well, no, it might be a weeny part in it, but I really get so much joy out of Charlotte, and, you know, but maybe it's just, they're so rare, even more rare than sperm donors. He reckons now that we've got the kids, I probably wouldn't be able to disassociate myself from that curiousness all the time. And I said, "Well I've seen what's happened with Rob and with Phoebe," and I said, "I think I could just give for the sake of just giving. Just to give another couple an opportunity to be parents." And he says, "It all sounds really good Sarah, but you know you're a highly emotional sort of person and are you trying to kid yourself?" And I said, "I don't think so." I mean, not to say I wouldn't ever have those curiosities, like an adoptive parent does.

Sarah's claim that Tim questioned her motives, which she acknowledged involved some self-interest as well as an altruistic motive, suggests that Tim, like some female partners of sperm donors, might have had a sense of 'ownership' of her eggs. He also appeared to equate donating eggs with having a child. His discomfort might also indicate that it served as a reminder that she could become a biological parent and he could not.<sup>25</sup>

Sarah's claim that she did not expect to feel overwhelming attached to a child conceived using her donated oocytes is supported by the findings of qualitative research on egg donors in Australia which explores the experience of egg donation from the donor's perspective (see deLacey, 1995a, 1995b). DeLacey argues that some studies of egg donors showed that oocyte donors anticipate a sense of 'connectedness' with a child born of their donation. According to deLacey, fear of this connection leading to a feeling of 'ownership' has led to the development of exclusively anonymous egg donation programmes in some countries (see Raoul-Duval et al, 1992). DeLacey argues, however, that due to the limitation of the quantitative methods employed in this research, the nature of this connection and its implications have not been defined. In her study, carried out in 1994, deLacey (1995a) found that oocyte donors defined feelings of 'connectedness' as genetic affiliation, natural interest and curiosity about the children, not as a sense of 'ownership' or 'maternal attachment'.

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<sup>25</sup> For a discussion about the motivations for becoming a donor, see Chapter Five.

Caroline, another mother of two daughters conceived by DI, had written to the donor through the fertility clinic as a way of ensuring that her daughters would be able to gain access to him in the future. She and her husband Mike said:

Caroline: I wrote this letter about three years ago...Basically, I said I really want you to get in touch with this donor, because...and I had a letter to give to the donor and I said these are our reasons for it. The way I look at it, when my girls get older it'll be like a little piece missing out of a puzzle, and I want it so they can complete it. They may never want anything to do with this man, but I don't want it to be seen that I never did my bit to help them do that, because I think them both being females they are more likely to want to trace it than I think males would, and I think it's just a female thing. It's a very maternal type thing. So, it was probably more my driving force than yours, I think.

Mike: I was quite supportive. I thought it was a very good idea. I wasn't against it. But Caroline would definitely have been more bothered about doing it.

Caroline: Originally, [the clinic nurse] had got back to me on it and said, "we don't know where he is at the moment" and I said, "you're really going to have to find out where he is, because if you don't, I'm going to have to take some other measure to try and find out where he is." I now feel the real need that I need to know... I don't need to know who he is, but I need to know that if my girls want to get in touch with him, they can do so. So after really stressing the point to her, about two days later she said, "Oh, we have actually found him now". So, they had found him and they had given him my letter, and he has apparently left his solicitor's name and this solicitor will always know where he is, hopefully. So that if we need to then obviously my girls will get in touch with the [clinic].

Caroline saw her motivation to make contact with the donor in essentialist terms which was reinforced by her husband. Iwanek (1998:28) argues that it is a myth that more adopted females trace their birth parents than adopted males do. She contends that adoption orders made in Wellington, New Zealand, courts between 1965 and 1975 were 44 percent for males and 56 per cent for females, and applicants for information under the Adult Adoption Information Act represented the same gender ratio. Caroline's reference to the donor as "this donor" and "this man" simultaneously highlights the gulf between the unknown donor and the anonymous recipient, and also constructs the donor as provider of a (missing) piece of the puzzle that constitutes her daughters' lives and genetic makeup.

The question arises whether just as birth mothers are the key gatekeepers to birth fathers when children are adopted, so *some* birth mothers like Caroline may assume a special responsibility for access to the genetic father of her children. Caroline and Mike's donor had donated at a time when donors were not asked to indicate whether or not they were willing to be contacted by recipient families. This was initially of

little concern because their overwhelming priority was to have a baby, but as her daughters had grown, Caroline had become more concerned that they could make contact with the donor, and she, herself, had become more interested in him. In relation to the possibility of meeting the donor, she and Mike had this to say:

Caroline: Yeah, I would love to meet this person [the donor]. I probably wouldn't do it, I think, until the girls got older.

Mike: I would not want to meet the person unless the children wanted to meet him. I'm quite happy to meet him, but I think... from what I gather he's ten years plus older than us, so he's an older person. He's remarried. He's possibly got new children. I wouldn't want to put him in any form of spot without... because we accepted the rules as they were, and we're thinking of the interests of the children, so if and when they meet, then I'm quite happy to meet him. I'd like to meet before, but I don't think it's fair to him to do that.

Mike raised the issue of the donor's right to privacy. He raised a set of issues related to timing for the donor, whose circumstances also change over time. Mandy, Caroline's sister, expressed a concern that the donor be protected from unwanted approaches. She commented on Caroline's attempt to ensure that the donor was available to meet her children in the future:

Mandy: I think the way Caroline's doing it, they're going through a lawyer, and I actually think that's probably a good way, because then you've got a third party in there, who [can mediate]. It's hard, because, yes I think Toni and Lucy have a right to know who their father is, but then, like this friend of ours [whose husband was a donor before he married] who's now got four children, you don't want them to impinge on their life that they've now got.

KH: So donors have their rights as well?

Mandy: Yes. And I think, especially in those early days, it sounds like they didn't sign a form saying that they would be available and it was probably a mistake by the donor insemination [programme], because they should have... So, I can see why now they would not want to, because they probably thought they could be anonymous, and they were doing something that would never come back to haunt them in later life, and now it is.

These comments illustrated the ethical dilemmas that might arise for donors who donated at a time when they did not agree to be identified, and were later asked by the fertility clinic if they were prepared to be identified. Mandy had been alerted to this by a friend, whose husband had donated anonymously before he married, who felt strongly that any donor offspring should not be entitled to meet her husband and “intrude” into her family life. At the same time, Mandy empathised with her sister's desire to meet the donor. She said:

Mandy: Yeah, I suppose for her she's probably interested because she'd like to see where her child gets different aspects from. It's funny, because I know things that my kids do, and I think... "You're just like your father," and then you wonder, like Caroline might jokingly say that, but they'll never know, and that would be interesting to know different little characteristics.

Mandy raised the possibility of mothers of children being interested in meeting the donor in the same way that individuals conceived by DI, or adopted people for that matter, might wish to find out where certain of their characteristics or looks originated.<sup>26</sup> Considering the intimacy involved in carrying a child to term, and the unusual circumstances of having virtually no knowledge of the genetic father, let alone a visual image of him, it is perhaps not surprising that some women might have an interest in meeting the person who contributed to the procreation of their child.

As a result of the expression of interest in donors by some mothers, some health professionals speculated whether the desire for contact between some recipient families and donors would be prompted by mothers, rather than the children themselves. Dr A had this to say about children possibly wanting contact with donors:

Dr A: I would assume that there would be a significant group that would want to. And it may not be the children that want to do it. There seems to be a moderate amount of pressure from the mothers, if you know what I mean. Maybe those mothers are wanting to protect and think for their child, but it may be something else. I don't know.

Dr A speculated whether some mothers' interest in knowing more about the donor was prompted by personal interests. This raises the question of whether women who have borne a child conceived by DI might be interested in men who shared with them the status of biological/genetic parent.

Other health professionals spoke of the need to protect both donors and children, especially in situations where parents had separated. A nurse at one of the clinics indicated that when couples separated there was a danger that the mother might try to turn the donor into a father figure for her child.

Kathy, the mother of Melissa, aged 10 years, had been given no information about Melissa's donor. Although she accepted the lack of information about the donor at the time of the insemination, she said later she began to feel that it was important that

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<sup>26</sup> The significance of physical resemblance in families is discussed in more detail in Chapter Eleven.

her daughter had access to information about the donor, and wrote to the clinic. She said:

Kathy: We did write. I have since contacted them again and asked for further information, which they were not forthcoming with at all. They said they didn't have anything else on file and it wasn't their policy to obtain any further information for anybody. At some point I did push the boat out because in those days they tended to shred the information on the donors. They didn't keep them. I tried to do it the nicest way I could and I thought, "How will I guarantee that these records are actually going to be kept?" ... If the clinician drops dead, well, the information goes. I didn't want that to happen. At that point I realised I had quite a big responsibility. I'd brought this child into the world and I had to ensure she had some kind of ability to have those records if she needed them. ... As far as I'm concerned there's two cross records [the donor's and Kathy's] and we really need to hold that information... we've produced a child out of it. And I would have stood the ground in my own right at the time. But really my interest is... I don't have a need to know, but I knew somewhere down the line she'd be the type of kid that would ask a hundred questions and she does just that.

Kathy was thwarted in her desire to receive more information about Melissa's genetic father because the clinic was unable to furnish any further information about a donor who had not agreed to it. The director of a fertility clinic said that two recipient couples had contacted them to ask for more information about donors.

Dr C: One couple we feel very embarrassed about but, because the letter we received requesting more information I passed on to our nurse and I think I then went on leave, and when I came back she had lost the letter, and she couldn't remember the name of the person. And so we're hoping that they would write again, but nobody's written.

There's another couple where we sought more information from the donor and they refused. And I agreed to contact the donor again in a year or two... but we actually got two ethical specialists to look at the case and they said that we didn't have the right to pursue the donor for more information. It's actually got quite messy I'm afraid. The couple separated...

Although Kathy claimed that she sought the information about the donor purely on her daughter's behalf, her actions coincided with her separation from her husband. At the time of the interview, she indicated that she was quite interested in meeting the donor.

Kathy: Now I would, and that is probably based on looking at Melissa. I look at her sometimes and think, "Who are you like, you pretty baby?" Yeah, I would look at her sometimes and I think there's a lot of talent, there's a lot of unknown quantity in there. And I think somebody's given me such a great gift, really, and yeah there's so much about a whole side of her that I just don't know anything about. I mean, I look at Nicole and I know her father and I know all those things in that whole family, and it's like, there. It's not a biggie for me, but it's there. I often look... I mean Melissa's extremely artistic. She's my artist. And she's been a finalist (she points to Melissa's painting hanging on the wall).



Kathy focused on Melissa's giftedness, her good looks, her artistic talent, and her curiosity about everything. And she wanted to be able to establish whether these attributes were those of the donor or other members of his family, about whom she knew almost nothing. Kathy's interest in meeting the donor might also be attributed to the significance she attached to kinship based on biological ties.<sup>27</sup>

Joanna, a separated mother of two children conceived by DI, hoped that the donors, whom she referred to as her children's "fathers", would be available to meet them. She said:

Joanna: It's quite good, Todd's father doesn't mind meeting the children when they're a bit older, past their teen years, through a third party, whereas Jessie's father doesn't mind meeting the children any time at all. I'd quite like Todd's donor [to be available sooner], because I mean, teenagers, they're a bit funny at that time of life.

Joanna's concerns that the donor be available to meet Todd possibly relate to the allegedly poor relationship between Todd and his social father. According to Joanna, Todd had recently said that if anything happened to her, he did not want to live with his father. Joanna's estrangement from her husband might have contributed to the donors appearing more significant. She described them as follows:

Joanna: I know that one's married with two children, that's Todd's. And he's 9 stone and only about 5'9", a real weed. He's an accountant and he's got bursary and all his schooling and that. And he enjoys cricket and the piano. It's funny because Todd enjoys cricket and the piano. Just things that come out. Todd is an A-grade student at school and maths is one of his best things, so it's funny how things come out.

[The other donor is] an older man. He's in his 50s and he's single and has had no children. And he's an historic writer with an American background. He was born here, but his parents are American. He's 5'9" too, but he's a more solid build, and he's got an eye problem, which was funny, because Jessie was born with a turned in eye, but she's got it all checked out. He had surgery on his eye, because he had an eye problem, but Jessie is all right. So... and he likes collecting cars and horse riding, and I thought, oh dear, he's just like my father... with all those car bodies and that lying around. But she should have been a boy, she's a real boy. She really is. She was a prem[ature] baby and she's a real fighter (she laughs). Always will be I think. Determined.

Joanna spoke in more depth than other parents about their sperm donors and offered the most detailed comparison of the donors and her children.

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<sup>27</sup> See Chapter Three for a discussion of the primacy given to biological ties in Euro-American kinship ideology.

Carla was explicitly interested in meeting the donor because of the loss of strong ties to her husband and to other family members. She said of the donor:

Carla: Well, he did an amazing thing in giving life to Justine, and I mean, I don't want to deny him that, if you know what I mean. I'm not going to give him visiting rights or anything, but that is a pretty special thing to do and he did actually partake in making Justine. And I don't have a problem with the fact that he is the father. Probably more because Ben [her ex-husband] and I aren't together, too, in that Ben hasn't been a real father in the home either. So, there were some amazing things going through my head when Ben left. Well, who is the Dad here? Is it the one that made her or the one that's just gone off and left her or, does she have a Dad? But I've resolved a lot of those things.

To some extent Carla recognised the donor as her daughter's "father" because of the gap left by Ben, Justine's absent social father. She also refers to him as "the one that made her" which implied some purposive action on the part of the donor. Although Carla said that Justine now had a good relationship with her father, she felt some bitterness about his having left her 'holding the baby', and did not believe that he adequately filled the role of father to their child. She expected that Justine would want to make contact with the donor:

Carla: I have the expectation that she will; whether she does or not is up to her, and I don't want to impose that upon her. I'll try really hard to leave it open. It's up to her and if she has no desire then that's fine. But, I personally have a desire.

KH: Would you like to meet him?

Carla: I would, just to say thank you. That would be the overwhelming thing, just to say thank you.

KH: When you say that you have a desire, do you mean you think it might be good for her to meet him?

Carla: Having been raised by a stepmother and lost contact with my own real family, I think that family is important. Like, I'm lost: I don't belong to my step-family; my Dad's family, a lot of them have died, and I wasn't raised with them either, and I'm like a lost wee soul in the world, and I think that family's really important and I would like Justine to have some link with family. There's very little for her, because my Mum's a step-mother, so she hasn't got a real grandmother there. Ben's side of the family consider that they're not her real relatives, so we've got problems there. And my Dad adores her because she's his grandchild, but I mean, he's not going to live forever and there's not a lot. I have a step-brother and a real brother, but he's fairly removed and not that interested in children. So, family's not going to be huge for her, and so if she can find identity... And for me, not having known a lot of things about my mother because she died, and the family didn't want to talk about her, then I hope that things are more open for Justine, and if she does want to know those things, that it's there for her.

Carla's desire to have contact with the donor appeared to be related to her perception of the paucity of 'real' relatives, or 'real' family, in her life, and in Justine's life. Thus, she made a strong distinction between biological and social ties: she categorised

the former as unproblematically positive and meaningful and the latter as negative, insignificant and uncaring.

## **Conclusion**

Talk about donors illustrates the uncertainty that surrounds the meaning of sperm donation. It highlights a range of issues relating to donors, people conceived by DI and their families, and the sets of competing 'rights' and claims parties to a DI conception have to one another. Questions arise about whether or not people conceived by DI will be interested in identifying or meeting donors. Clinical staff working in two New Zealand DI programmes did not anticipate that many people conceived using DI would be interested in identifying donors. In support of their views, they drew on the experience of adoption. For example, they anticipated that the lack of a social relationship between mothers and donors, that the child was not 'relinquished' by his/her parents, or that adopted people appeared to be more interested in locating birthmothers than birthfathers, indicated that it was unlikely that large numbers of people conceived by DI would be interested in identifying donors. These views, however, are speculative, and if comparisons are to be made between adoption and DI, it should be noted that adopted people seek their birthparents or information about their biological origins for a variety of reasons that could conceivably apply to people conceived by DI.

This chapter has shown that the level of interest in donors by recipients and their kin varies considerably, from total lack of interest, to a desire to meet the sperm donors. This has implications for the implementation of policy relating to information-sharing in this area. Many parents of children conceived by DI wished to remain anonymous to donors. While most of these parents thought it the child's 'right' to know about their DI origins, and even to identify or contact the donor, they neither expected nor hoped that their child(ren) would want to identify the donor. While most parents expressed their gratitude to the donor for his altruistic 'gift', many perceived his role as one of providing genetic material to enable them to have their 'own' child. For many of these couples and their kin, immediate family relationships were of primary importance and they did not wish to attend to the possible significance of genetic ties. They sought to maintain their 'right' to privacy and to freedom from the possibility of donors 'intruding' into their family lives. Thus, they appeared to wish to maintain the

integrity of the nuclear family. Those who were more likely to prefer the preservation of anonymity employed a variety of strategies for maintaining anonymity, which denied the donor any 'ownership' in or access to their child, and reinforced the social father's position as the only father of the child.

Parents and their kin presented a broad range of notions in their construction of sperm donation as a gifting act, which sometimes correlated with the way they conceptualised and reacted to the identifiability of donors. This illustrated Simmel's (1950) arguments about the significance of gratitude in social life and that it may or may not engender reciprocal acts. Those who were less inclined to feel grateful to donors for their 'gift' were also less likely to welcome any contact with them in the future. Gratitude to the donor, however did not always mean that a direct connection with him was seen as appropriate. While some parents' gratitude did not engender any reciprocal acts, others wrote to the donor anonymously through the clinic, and some sent photographs of their child. Writing to thank donors was also used by some couples as a means of ensuring that the donor would be available to be contacted in the future if the child initiated it. Some women planned to donate their eggs to another infertile couple as a means of reciprocating and expressing their gratitude for the 'gift of a child'.

Talk about donors also illustrated the lack of adequate vocabulary to enable people to think and talk about them (see Snowden, Mitchell and Snowden, 1983). Because language constructs meaning, this indicates that it is important to establish a nomenclature that adequately describes the donor's role in the procreation of a child. Donors were variously labelled by parents as "dad", "biological father" "this man" or "this person", the latter of which positioned him as an outsider to their family, and thus depersonalised and marginalised the donor. Other parents used language related to adoption or fostering discourses, referring to donors as "birth fathers" or "natural fathers". Some extended family members said they knew very little about the donors, and some conceptualised their contribution to the conception of the child as a "non-issue", "a chemical thing" or a "gift from one family to another". Thus, they drew on discourses of gifting and science that tended to distance and depersonalise donors. Others, however, referred to the donor as the child's "father" and expected that the child conceived by DI would want to meet him in the future. This raises the question

whether the terms ‘father’ or ‘dad’ should be used in relation to the semen donor who has no social relationship with the child. Equally, with the increasing use of third party gametes in assisted conception, the question arises whether it may become more widely understood and accepted that people can have more than one father or mother.

Conceptualisations of, and interest in, donors appeared to change over time. This highlighted that some of the views expressed by parents and their kin might change in the future, depending on a variety of contingencies. Some parents maintained that, while they had not been interested in the donor at the time of conceiving by DI, over time they had become more curious and wished they knew more about the donor. Some of these parents expressed concerns that identifying donors might complicate their own, or their children’s lives. They nonetheless conceded that their children would have a ‘right’ to do so. This illustrated the extent to which some parents and their kin drew on discourses and public narratives related to adoption or fostering, and the possible risks involved in the ‘search for origins’ to frame their fears and expectations.

Several parents anticipated that their children would want to identify the donors in the future, and some had actively sought to contact donors to ensure that this would be possible. Others raised the question of whether donors might be interested in identifying their DI offspring. Parents who were the most ‘open’ to meeting or incorporating the donor in some way were predominantly people who had experience of a father or husband gap in their lives or split biological/social rearing. Others who expected their child might wish to identify the donor had chosen a Maori donor and recognised the importance of whakapapa. The views and experiences of these parents highlight the need to acknowledge that many families in contemporary New Zealand society are negotiating complex kin relations in the context of forming families. This, in turn, indicates a need in New Zealand to establish a regulatory system and a register of donors that at least ensures that DI offspring have access to information about donors, and perhaps provides access to identifying information to all parties to a DI conception.

The chapter raises issues about competing ‘rights’, such as the right to privacy, raising questions about the formulation of policies around information-sharing in the context

of DI conceptions. For example, some mothers expressed an interest in identifying and possibly meeting their donors, and were perceived to have their own interests in identifying donors. For some health professionals, this interest highlighted the need to protect donors and their families, and children conceived by DI. Issues also emerged relating to timing for donors whose family circumstances may change over time. This study has shown that women who were no longer living with the social/legal father of their child, and had tenuous ties with other family members, were most likely to express the desire that the donor should be available to meet their child. Some also hoped that the donor might be available to fulfill a father-like role in their child's life. Expectations such as these should be acknowledged in clinical practice, though they appear unrealistic considering that donors legally have no rights or responsibilities in relation to their DI offspring.

This chapter has illustrated a variety of responses to issues relating to donors, children conceived using DI and their families. It has also illustrated the existence of competing 'rights' of donors, social fathers, mothers, and people conceived by DI to access to information and identification of the parties involved in a DI conception. While everyone recognises the right of children to know something about their genetic fathers, parents and their families vary in their attitudes to contact with donors. Some parents accept the possibility of such contact, but would rather avoid it. Others positively embrace this possibility and want to ensure that their children can make this contact in the future. This highlights the diversity among DI families, and the complexities that need to be taken into consideration in the formulation of policies and practices particularly in the context of information-sharing in DI.

## Chapter Eleven

### Conceptualising Families: Difference, Sameness And the Use of Donor Insemination

It is time to lay to rest the ghost of The Family so that we may begin to build a safe world for living families. The family is dead. Long live our families! (Stacey, 1996:51)

#### Introduction

‘The family’, as a unitary concept, has been problematised by sociologists and social scientists who argue that a diversity of family forms is evident in society (Pryor and Rodgers, 2001; Smart and Neale, 1999; Silva and Smart, 1999; Morgan, 1996; Stacey, 1996; Coontz, 1992, 1999; Gittens, 1993; Macklin, 1991; Gubrium and Holstein, 1990). These authors argue that what is commonly understood as ‘the family’, as one dominant family form, simply does not exist in contemporary western societies. As discussed in Chapter Three, a renewed focus on ‘the family’ has moved away from a structuralist view of ‘the family’ as an institution. Instead, major theorists, such as Giddens and Beck, avoid using the terminology of ‘the family’, focusing instead on intimacy, child-parent relationships, or what Morgan (1996) refers to as ‘family practices’, or engaging in actions that constitute categories of people as families.

Drawing on these contemporary understandings of family diversity, this chapter argues against a ‘DI families’ frame that defines families with children conceived by DI as a unitary category. Rather, the chapter focuses on parents, children and extended family members who have to respond to a set of issues relating to the genetic contribution of donors. Other families respond to such challenges as multiple births, the knowledge that a child was conceived outside the marriage, or to the diagnosis that a child has cancer. These things highlight common assumptions, and bring discourses about family, love, and parenting into stark relief. Analysis of the interview material indicates that people in families with children conceived by DI respond *differently* to the complex issues and challenges they face, illustrating the diversity that exists between families that are generally defined as belonging to the same category.

Sociologists and social scientists have drawn attention to the effects of the use of reproductive technologies on the meaning of 'family' and related concepts such as 'motherhood', 'fatherhood' and 'parenthood', particularly when third party gametes are used (Almond, 1995; Macklin, 1991; Edwards, 1991; Eichler, 1989). Much of the concern about the implications for families of conceiving a child by DI is shaped by assumptions about biology and social relationships, particularly the view that ties between parents and their children 'naturally' have a biological/genetic basis (Haimes, 1990). As Stanworth has pointed out:

In the dominant culture of Western societies, the importance of blood ties is a powerful cultural theme. The family is often imagined as a biological unit, in which social relationships grow straightforwardly out of genetic ones, such that commitment to 'the family' and to 'blood ties' becomes inseparable in many people's minds; the overlapping responsibilities of mothers, fathers and children are filtered through a biological lens (1987:20).

This pervasive and important cultural theme may have particular implications for couples who conceive children using donated gametes. Stacey (1996:49) has pointed out that while the modern family system, incorporating a male breadwinner, married to a homemaker, and their biological offspring, might be defunct, its "ghost" lingers in the form of the ideology of the family which pervades general understandings of what is meant by 'family'.

Gubrium and Holstein (1990:133) have argued that family ideology acts as a form of normative control: the use of the discourse of "The Family" promotes a sense of what ought to be as much as it suggests what actually exists. These authors contend that, as a means of social control, family usage simultaneously creates and controls the social order it purports to describe: family imagery may recommend particular social relations and arrangements as 'normal' or 'expected' while proscribing others (Gubrium and Holstein, 1990:132). Adoptive families, and those including children conceived using DI, disrupt assumptions about the 'naturalness' of families. They highlight the differences among families (Humphrey and Humphrey, 1988). In everyday discourse, 'other' families are qualified, such as adoptive families, foster families, step-families and DI families. According to one adoption researcher, acknowledgement as opposed to denial of difference has led to more open and creative relationships between children and their adoptive parents (Kirk cited in Iwanek, 1997:17; Haimes and Timms, 1985:83). Acknowledgement of difference,



however, can also reinforce the dichotomous relationship between the biological and the social which, as discussed in Chapter Three, has been challenged and disrupted by many theorists (Carsten, 2000).

Rather than contending that families conceived by DI constitute a particular ‘family’ type, this chapter illustrates diversity of experience and difference among these families. Gittens (1993) has argued that having children creates new power relationships between mother and child, father and child, mother and father, and siblings. In the context of conceiving a child by DI, these power relationships are intersected by the knowledge (at least for the parents themselves) that the father is not genetically tied to the child, while the mother is both biologically/genetically and socially connected to the child. Questions arise about how various members of a family respond to and use this knowledge in their day-to-day familial relationships, and how this affects their understandings of ‘family’ and related concepts. Importantly, parents who are using DI to conceive their children are doing this in the context of *general* ‘troubling’ of what we understand by families and a world in which children are generally less likely to live with their genetic/biological fathers.<sup>1</sup>

The chapter begins by examining the ways in which parents and family members of children conceived by DI conceptualise their family, and whether or not they think of their family as being ‘different’ from other families. The ways in which children conceived by DI are conceptualised as ‘different’ or ‘special’ are also explored. The issue of physical resemblance and the importance attached to this in the context of family formation is a focus of attention. Another focus of this chapter is the implications for parents’ relationships and the problem of ‘asymmetry’ in connection with the missing genetic link between the father and the child conceived by DI. The concluding section of the chapter is a discussion about the meanings attached to the missing genetic link and the ambiguities and uncertainties that emerge as a result,

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<sup>1</sup> New Zealand census data show that families consisting of two parents with children declined from 53.2 percent in 1986 to 44.9 percent in 1996 (Statistics New Zealand, 1998:15-17). Over the same period, the proportion of one-parent families rose from 14.3 percent to 17.7 percent. Twenty-eight percent of all families with children were one-parent families, and 83.1 percent of sole parents in 1996 were women. Data from the Christchurch Health and Development Study indicate that over the period of childhood (0-16 years) 36% of the cohort of children included in the study had spent some period of time in a single-parent family with the majority (79%) entering single-parent families as a result of parental separation and divorce (Fergusson, 1998:158).

particularly in connection with the relationship between social fathers and their children conceived DI.

**Families with children conceived by DI: more of the same, and ‘different’**

The secrecy and anonymity that has traditionally surrounded DI has been attributed to the desire of couples with children conceived by DI, and health professionals who assist in these arrangements, for these families to be seen as ‘normal’ or ‘ordinary’ families (Haimes, 1990; Snowden and Snowden, 1998). In their study of couples who had conceived by DI, Snowden and Snowden (1998:46-47) found that many couples wished to appear like a ‘normal’ family to avoid what they perceived as the stigma attached to the ‘unnaturalness’ of DI conception, as well as the presence of male infertility. Additionally, the vast majority of couples kept their DI conceptions a secret because of concerns about the implications for family relationships. For example, many parents assumed that grandparents would expect their grandchildren to be biologically related to both the parents, and would be concerned about an imbalance created by the grandchildren being related on the maternal but not the paternal side of the family.

Secrecy, therefore, is seen as a means of enabling families with children conceived by DI to deny that they are ‘different’ (Snowden and Snowden, 1998:46). The concept of ‘differentness’, however, is complex and ambiguous: the question arises as to who or what these families are different from. Stacey (1996) promotes the celebration of family diversity, rather than the identification of families that differ from an overgeneralised ideological norm. However, given that family diversity exists alongside the powerful images of conventional heterosexual nuclear families, questions arise about whether people who have used DI compare themselves to other ‘types’ of family, or to some established ‘norm’ of what a ‘family’ ought to be. Questions also arise about the meaning of ‘different’, and whether being ‘different’ is regarded as neutral, as positive and valued, or as negative and pejorative.

Most couples participating in this research considered their family to be a ‘regular’ or ‘normal’ family. Joe and Ella, the parents of three sons conceived by DI, said:

- Ella: Because, as far as anyone else was concerned, they were conceived by us, and they were... we made them...basically Joe put the sperm in where it was needed. We made them.
- Joe: More of a triangle than a two thing...it's a three thing.
- Ella: With the help of someone else we've made these children.
- KH: Your own children. They feel very much your own?
- Joe: Mm. But again, I've got nothing... it's not as if I've had children which are genetically mine, and I can stand back and compare the two. I've got nothing to compare with, so to me that's the benchmark. That's normal.

To Ella and Joe, theirs was a “normal” family for several reasons. Their perception that others would see them as having conceived the children themselves, however, neglects the fact that many people know that their children were conceived by DI, because, Joe, in particular, had told many people.<sup>2</sup> This suggests that secrecy and denial of ‘difference’ do not necessarily go hand in hand. Because they had no other experience of having children other than by DI, it was ‘normal’ for them. Later in the interview, Ella said they might have felt ‘different’ at one time, but over time they believed the fact of having conceived by DI had receded into the background as they lived their day-to-day lives like any other family.

Ella hinted that they had had certain issues to deal with that other families did not. Some extended family members indicated that, while they had thought that the problem of infertility was resolved by having a child, it appeared that some problems related to infertility were on-going. Jeremy and Christine, the brother and sister-in-law of Richard and Belinda had this to say:

- Jeremy: I think that from what it looks to us, it is still a fact of life, they are still an infertile couple, though an infertile couple with a baby.
- Christine: Yeah. I think they were very excited that the baby came and it seemed all of a sudden that they didn't need the Infertility Society any more and the people associated with it, and I could understand that.... But I also felt like, once she was born then there were things like, you know, “Who does she look like?” When Thomas [their son] was born everybody was talking, “Oh, he looks like this and he looks like that,” and I knew that they would strike that. And, even if they had their baby and that solved their problem, it seemed to me that it would bring a whole new set of problems with it that perhaps they did need the support of people that really understood. I mean, we can try and understand, but we can't really understand what they've been through.

Hammer Burns' (1990:183) study of perceptions of parenting after infertility shows that most couples reported that infertility had caused conflict in their marriage, and

that conflict in the marriage during infertility may be unresolved and subsequently carried over into their parenting practices.

Some parents of children conceived by DI acknowledged that they had different issues to deal with as a result of conceiving a child in this way, but denied that their family was ‘different’. Kathy said:

Kathy: Well, in today's world there are a lot of different families and there are a lot of different inter-related families and ours... no, I don't see us as different. I've got different issues to deal with. And it's a matter of making the most positive way into it. No, I wouldn't say different at all.

Neil, too, said he did not think of his family as ‘different’.

Neil: I've become aware of the many different ways of forming families... whether it's via adoption or ART, or other means. I don't see one lot as being normal and one lot as being special or different.

In contrast, Sarah, the mother of four children from a variety of ‘origins’, thought of her family as special in some way, but not ‘different’. She said:

Sarah: I don't see us being as different, um, unique, but I've never wanted to be like anybody else. When I was a teenager I wanted to wear glasses and braces because it was embarrassing to do so and I was going to do it and not be embarrassed. I mean, I guess both Tim and I have got... kind of got a rebel streak in us. So we don't see ourselves as ‘different’. We called ourselves either extraordinary, or special. ...It's a toughie though. I mean, because Tim and I were probably different before we had kids (she laughs). So, we're not different now.

Sarah juggled with a variety of discursive frames connected with the meaning of being ‘different’. She preferred to see their family as “unique” or “special” rather than the more pejorative ‘different’.<sup>3</sup> She claimed that she and Tim liked to be ‘different’ from the crowd in the sense of not being ordinary. Having said this, Sarah intimated that they were ‘different’ before they had children, which suggested that unlike other forms of differentiation, being childless was a form of being ‘different’ that Sarah did not value.

Other parents claimed that if they thought about their family as ‘different’ from other families, it was along a variety of dimensions other than the origins of their child. When asked if she saw her family as ‘different’, Meredith, the mother of a son conceived by DI, replied:

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<sup>2</sup> See Chapter Eight for a discussion of Joe and Ella's views on secrecy and disclosure.

Meredith: No, as I said, that is a closed book. I don't see any difference. The only difference is that there's only one. Not having any brothers and sisters, because there's no way I'd go through all that again.

Perhaps partly because of the difficulties she had encountered having a child, Meredith and her husband chose to put their son's DI conception 'behind' them, and had no plan to tell their son about it. While it has been argued that secrecy serves to deny the DI (Snowden and Snowden, 1998:46), rather than denying the DI itself, Meredith appeared to want to avoid confronting the issues that emerge for parents of children conceived by DI, at a time when there is pressure to tell.

The importance attached to having more than one child was raised by Paul, a father of a daughter conceived by DI, and an older son conceived without assistance.

Paul: I think that [having another child] was quite important because up until that time it was, well for me anyway, I sort of, we had a family but it was...having two children seemed to make us more of a family, from my point of view anyway. It just seemed to be more complete.

For Paul, having a second child, no matter how she was conceived, assisted in a normalising rather than a differentiating process.

While they thought of their one-child family as 'small', Alice and Peter raised the issue of differentiation along a number of dimensions.

Alice: I guess when I compare it, I just think that we've got a small family (Peter laughs), because it looks like we're not going to end up having any more, and it feels like a small very close unit....

Peter: In terms of whether we are or are not a different sort of family. We probably are in lots of ways...because we're not married. We've never been, and we've been together...

Alice and Peter (in unison): 17 years.

Peter: ...or something. And we've been through all of this. We've never sort of had the need to marry, but um, as well as that, Erica's a very special child to us because of the process and, you know, her sort of innocence in the whole thing. They don't have any say in it. So, I think we are a bit different. We don't... it's nothing you think about very often, but I think you value what you've got more.

Peter located their 'differentness' in their marital status and the process by which they brought a child into the world. He appeared to perceive these points of difference as positive and valued.

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<sup>3</sup> Conceptualising the child conceived by DI as 'special' or 'different' is discussed later in this chapter.

Like Peter, Andrew and Annie considered that they appreciated their children more than many other parents. This assertion was made in the context of denying that their family was ‘different’.

Annie: I think we're a healthy family and have a lot going for us as a family, as the four of us.

Andrew: I appreciate my children more I think than perhaps other people do who just have it because it happens. I think I appreciate my children a lot more, even though I haven't had a lot to do with them.

Annie: Well I have, and I hear other parents moaning about things about their children, and I get very intolerant because they're so lucky to have their own children. And they don't know. I might have been the same. I might have been the same had I not been through what I have.

Andrew and Annie appeared not to wish to associate themselves with the pejorative connotations of the word ‘different’. Although he said he had not spent a lot of time with them, Andrew valued his children after his experience of infertility and conceiving through DI.<sup>4</sup>

Some parents argued that perceptions of being “different” were embedded in particular social contexts. While she initially denied perceiving her family as ‘different’, Alice suggested that:

Alice: I do [feel ‘different’], actually, in one context, and that's when we meet with our antenatal classes that we went through with Erica when she was born. Almost all of those women (there are only two of us who are not onto the second child already) have had the second child or are about to, and I do think about it there. We never disclosed to that group about Erica being different, and you know I do feel the difference a bit there.

Pippa, another mother with a daughter conceived by DI, said she felt somehow ‘different’ from others in her antenatal group with whom she had not disclosed about her DI conception. While her husband Sean denied that they, as a family, were ‘different’, Pippa remarked:

Pippa: I think it's more an issue with me than Sean, because I'm at the antenatal groups and I can remember one at the very beginning, and they were saying something about how important that the genetic link is for fathers to bond to their babies. And I find that quite hard.

KH: Did you disagree with them?

Pippa: I just didn't say anything. I might have said, “I don't know if it's true, because adopted children get loved just as much.” But, yes, they were onto this genetic thing, and every now

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<sup>4</sup> See Chapter Four for an account of Andrew's response to his infertility.

and again it's like, how much they look like each other, you know, how important genetics is, and genetics or the environment.

Alice's and Pippa's experiences raise the issue of whether the concept of being 'different' is more likely to be attributed to a person or a situation which is unfamiliar, or not well understood. Illustrating this point, a family member of one couple with a child conceived by DI said that she did not think of her brother-in-law's family as "different", because she knew them all so well. Related to this idea, Haimes (1998:55) argues that people conceived by DI are construed as 'different' because it is assumed that there are very few of them, which suggests that these conceptions are rare and therefore 'special'.

Some mothers perceived their families as 'different'. They were more likely to compare their family to the norm of the 'traditional' family, comprising a mother, a father and their biological offspring. Jane spoke about her sense of difference from others.

Jane: I sort of feel that you can't talk...because you actually go through a situation of having a donor, I sort of feel that you're different, I mean, different from other people, because you don't just have the children naturally, so it will immediately, yeah, I sort of feel from the beginning you're in a different situation.

KH: So you see your family as different?

Jane: Yeah, different to other families, yeah.

Jane claimed to think of her family as "different" because the children were not conceived 'naturally' and that, as a result, she ought to keep their origins a secret.<sup>5</sup>

Acknowledging 'difference' was seen by some parents as being 'honest' or accepting 'reality', but again this was in the context of comparing themselves with the traditional nuclear family. Carla had this to say:

Carla: We are different, and I think if you denied that and tried to pretend that you weren't, that maybe you wouldn't be seeing things. How do I explain that? I think it's really important that it's open and honest and that if anybody that was close to me did have a question or a problem that I'd like them to be able to talk about it. And people have asked me all sorts of things through the time, about how I felt about it, or whatever, and that's fine. I don't mind. I'd rather that things were open. And open for Justine's sake, in a way, too. I don't want anybody at a family reunion dropping a bombshell on her saying, "did you realise that you were this or that?" So, yes, I do

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<sup>5</sup> For a more detailed discussion of Jane's conflicting views on secrecy and disclosure see Chapter Eight.

see us as slightly different. And I know that even as a single parent family, Mum doesn't think that Justine and I are a family. She says that we don't class as a family and that's been hard at times too. She doesn't think that just one mother and a child is a family... [In another way] we're a little different as well...there is this third person that's been part of this family.

Lesbian families have to confront 'differentness' in ways that heterosexual couples do not because it is obvious that someone outside the lesbian couple's relationship must be the father of the child. Lesbian parents, however, respond to this particular issue differently illustrating that, just as there is no standard 'DI family', no standard 'DI lesbian family' exists (Haimes and Weiner, 2000:485). When asked how they would respond to questions from their daughter, Lydia, about being 'different' from other families, being raised by two lesbian mothers, Ria and Sophie observed:

Ria: I guess it's not something that I think about a lot. But I know that's something that is going to come upon us in the near future, so I do think about it occasionally, and I'd like to be informative to her about life in general before that happens, hopefully. To explain to her that there's just so much difference in the world.

Sophie: I think one of the reasons why we wanted to have our second child so close, is so that they will be close in age and able to be support for each other. But I really think that once they're at school age, or the age when children do realise differences, I think that it's not going to be so much out of the norm, because there are so many lesbian couples having...or gay parents, around these days. It seems to be happening more and more.

KH: Do you know of male couples bringing up children?

Sophie: I don't know of any, but I've heard gay men say that they would like to. I think that will be the next thing that does happen.

When asked how he would expect to respond to possible questions from Lydia in the future about her family arrangements, Derek, Lydia's genetic father, had this to say:

Derek: I'd just have to be downright honest and explain to her that I'm attracted to men, and that her biological mother was attracted to Sophie, and that we all wanted to have children, but really push the point that she's very, very lucky because she actually has three parents. And may even have four, if I have a partner. I'll be able to address it if it happens, but I also believe from reading the research, that usually doesn't happen, as long as the family unit is working. That she will accept it. She knows who her father is, but her father doesn't live with her. And at school I think there's a lot more solo parenting, or divorced parents that are living with a new partner.

Derek thought that Lydia would accept the way their family was formed as long as the relationships worked well. Furthermore, he thought their family arrangements would be regarded as 'acceptable' because Lydia would have contact with other children who did not live with their fathers.



Like many of the heterosexual couples, Petra and Jennifer said they did not perceive themselves or their family as 'different'.

Jennifer: I always get surprised when people mark us out as being different. But that's sort of a bit like being in a lesbian relationship. I just consider it to be normal, you know, it's normal. It's certainly normal for me. And then suddenly when someone says, but...blah, blah, blah, blah, it really hits me and I think, oh that's right, it's not totally accepted by some people. And it feels the same with Olivia. Like, Olivia is our normal family, and then suddenly...

Petra: We go to church, and it's not a gay church, although it's quite gay-friendly. And they accept us, they have learned quite easily to accept us as a normal family. So, they're really excited, because they've got a baby, and young couples with babies is what churches like in fact. That we happen to be both women is not a big deal. ...So we are normalised in enough places that we think we're completely normal. But just occasionally someone will say to me, "I get asked a lot of questions about your baby, or who your baby's father is." And I think, "oh shit, people are talking about us," and that's a real jolt. So that's a bit of a shock, but not as much as I thought. I thought we'd walk out with the mark of Cain, and in fact, like, we've just booked Olivia into [a centre] for child care and they've been really cool, haven't they? And I mean, her child carer is a very ordinary heterosexual woman with three sons, and...

Jennifer: I said to her, you know, "Is this going to be an issue for you?" because I thought it was better to deal with this up front, "and if it is, forget it, it's a non-starter." And she said, "No, no. It would be boring if we were all the same," was her response, which I thought was a really nice response. But it's...I deal with things that you're actually much better to be totally up front about that...

This discussion illustrates the contrast between self-perception and others' perception of 'difference', and highlights its political, contextual, dynamic and relational dimensions.

### **Physical resemblance**

For many couples, issues around difference and sameness emerged particularly in relation to physical resemblance between parents and their children. Families exist in time as well as space. The birth of a baby symbolises not only the continuity of life and the family, but also the passing on of physical characteristics that are often associated with a particular family. As a result, when babies are born, people tend to look for the ways in which the child resembles the parents or any other close family member. Physical resemblances thus appear to locate the baby as part of a family/kin group. As indicated in Chapter Three, Barnard points to the existence of three, rather than two, levels of analysis of kinship and relatedness: true genetic relationships based on the facts of reproduction; socially constructed 'biological' knowledge (a middle ground between the biological and the social, which is culturally specific); and social relationships (1994:788). Barnard (1994:786) argues that expressions such as "She has her mother's eyes" relate to culturally specific definitions of 'biology' which

may or may not have a basis in a true genetic relationship. Thus, physical resemblance belongs to the middle level of analysis with respect to kinship. As an illustration of the middle analytical level, Barnard suggests that in some cultures, for example, children are supposed to resemble their mothers' husbands because of the close physical relationship between husband and wife, and not because of the implantation of semen (1994:789). Barnard (1994:786) argues that even in Western societies, where social kinship is axiomatically bound to a 'biological' foundation, 'biological' kinship is as much a metaphor for social relations as a statement of genetic fact.

As discussed in Chapter Three, Strathern has argued that biological connections between individuals formed through the act of procreation are the cornerstone of Euro-American thinking about kinship and relatedness (1993:13). For participants in this research, the 'fact' that the genetic father of the child was an anonymous sperm donor led to concerns about what baby might look like, and that differences from the parents would have to be explained. Even though parents argued that in 'normal' circumstances a child may resemble one and not the other parent, for some fathers, comments from others that the baby did not look like them were a source of distress. The parents of a daughter conceived by DI commented:

Alice: I think it was difficult early on because she's such a spitting image of me when I was younger that the comments that used to come about that were difficult for you.

Peter: Yeah, they used to repeatedly, kind of, reinforce my relationship in the whole deal.

Alice: And even people who knew, I mean like family, would still comment on the relationship, which was kind of reasonable that they did, but made you feel left out, didn't it?

Peter: It used to actually annoy me [chuckles] something wicked. But you don't hear it very much any more.

Peter's response highlighted that in Euro-American kinship ideology, the child represents the symbolic fusion or unity of the couple and that, if not reconceptualised (e.g. by using physical resemblance as a metaphor for social relations) can become a symbol of disunity (Ragone, 2000:70). That fewer remarks about physical resemblance, or the lack thereof, were forthcoming as the child grew older perhaps indicated that, over time, she came to be seen as belonging to both her parents because of the social relationships that had developed. Alice and Peter had had to field remarks made by his great aunt, whom they had not told about their daughter Erica's DI origins. She had commented on how tall Erica was (in contrast to her

parents), that she could not “see any of Peter in her”, and “what was the milkman like?” Remarks such as these illustrate how people construct links between parents and their progeny by tracing a relationship on the body. They also bring into stark relief assumptions about family, relatedness and biological connections between parents and children, and that paternity (an invisible link to the child) is always potentially unknown (Gittens, 1993:66).

Several parents observed that it was commonplace for people to comment on likenesses between fathers and their children who were conceived by DI, even though, in reality, no biological/genetic tie existed between them. This further illustrates that people register relationships on the body, and supports Barnard’s argument that ‘biological’ kinship as expressed in terms of physical relatedness is as much a metaphor for social relations as a statement of relevant biological fact (1994:786). In many cases, family members and friends were unaware of the child’s donor conception, and therefore probably assumed the existence of a genetic connection between both parents and the child. Andrew, however, was all too aware of the lack of a genetic connection to his children, and became irritated when people commented on the resemblance between him and his eldest daughter.

Andrew: I found it very hard sitting there bouncing the baby and, “Doesn’t she look like you? No hair!” and all that sort of rubbish [laughter]. Give it a rest! Then you’ve got the other effect with Annie hanging around there as well, and knowing darn well [that the child is not genetically related to Andrew], and you’ve got these dopey people saying, “Doesn’t she look like Daddy?”... and the fact of the matter was, she was very much like Annie, no-one else but Annie. ...So that insemination was dominated by Annie, which to me has been quite comforting. If the kid had come out with strong tendencies to the other person, that wouldn’t have been as comfortable, and that’s turned out with the second one who has a tendency to be, not like...

Annie: We don’t know *who* she’s like! (they laugh).

Andrew: No idea at all. It ain’t like me.

Like Andrew, several parents with children conceived by DI commented about the ‘strong’ indication of the mother’s genes in the child. This might be explained by the desire to emphasise the primacy of the mother’s biological/genetic claim to the child over the donor’s. Snowden, Mitchell and Snowden (1983:141-142) also found that some parents minimised the role of the sperm donor in the creation of their child, contrasting the “brief role of the genitor” with the mother’s role of carrying the baby

to term. Highlighting the physical resemblance between the mother and child might also serve as a means of reinforcing distance and emotional boundaries between parents and donors (Ragone, 2000:71). As another distancing strategy, Andrew referred to the donor as “the other person”, rather than the donor or ‘donor father’. While he took comfort in the strong physical resemblance between his wife and their oldest daughter, he said their second daughter, conceived with sperm from a different donor, did not look like either of them. The possibility that their second daughter resembled the donor thus emerged, but neither Andrew nor Annie suggested this. The lack of resemblance between their daughters was a source of discomfort for Andrew and Annie because people in the community frequently remarked how different the girls looked from one another. This illustrates the way that physical difference creates more ‘distance’ between people, setting them apart rather than conferring on them a sense of belonging together (Ragone, 2000).

While looking alike can confer a sense of relatedness, many parents suggested that often children within families could look quite different from each other, even ‘full’ siblings. Differences were not always explained in terms of genetic inheritance, but as something common to families more generally. Ella noted that their middle child, Hamish, stood out as ‘different’ from his brothers primarily because of his social location in the family, and not because he had a different genetic father. Hamish was conceived using a different donor from his older and younger brothers, who shared the same genetic father. Ella conceded that Hamish was more heavily built than his brothers, had a different personality, and also did not get on with his brothers as well as they got on with each other. She attributed the latter to the small age gaps between Hamish and his brothers, and his being the middle child. Thus, for Ella and Joe, social positioning was seen as more significant than genetic inheritance when accounting for difference.

Similarly, Simon and Clare argued that their middle daughter, Maria, their only child conceived by DI, was different from the others, who were their genetic offspring. Her ‘differentness’ was not attributed to her DI origins. Instead, in their view, all families have a child who stands out as different from their siblings. Clare’s mother, Annette, invoked the same argument, telling the story of their son who stood out as somewhat “different”.

Annette: When I was complaining about our fourth child to our doctor, he said, “In a family you’re always going to get one who stands out as completely different.” He had four daughters, and he said, “I sometimes wonder where our Catherine came from.” So, I don’t see Maria as different. She is different, but I don’t think that is the donor or anything else. I just see it as the way she is.

Some parents highlighted the complexity of genetics and the inability to determine where certain looks or traits originated. Pippa and Sean said about their young daughter:

Pippa: I don’t think she looked like anyone. I *still* don’t think she looks like anyone. She’s got olive skin, but he’s [the donor] got a bit of Italian in him.

Sean: But so has your Dad.

Pippa: Yes, Dad’s got olive skin. He’s Lebanese. So it could be a combination, or not. You just don’t know.

The argument that a child conceived by DI did not resemble anyone but him/herself was also invoked by some parents to emphasise the child’s individuality and, in the process, minimise the role of any genetic contribution to his/her makeup. When asked if she saw her son as resembling anyone in particular, Meredith had this to say:

Meredith: I never think about it. He’s Daniel to me. And I don’t think about what he looks like, what he does, what he...or anything.

KH: So, you don’t make any kind of comparisons?

Meredith: Never think about it. But, I mean, when he was born, I know a lot of people said, “Oh, he doesn’t look like Karl. ” And that used to hurt Karl I think, you know. But, you see, as children get older you never ever think... so, no, we just get on with our life.

Meredith’s desire to “get on with life” indicated a desire to give primacy to social rather than biological/genetic ties. Inevitably, a child is born with a particular genetic makeup, but what really was most significant, in her view, was the social relationships that are formed as the child grows up within the family context.

Neil, who himself was adopted, said he could not relate to people who commented on family likenesses because both he and his sister were adopted, and looked entirely different. When he had children conceived by DI, however, he traced his birth parents for the first time, and then met his half-brother, which was first time he encountered family resemblance. He recalled meeting one of his half-brothers for the first time:

Neil: It was quite fascinating to meet one of my half-brothers who had a strong physical resemblance to myself, ah...prior to that, physical resemblances weren't something that I was interested in. In fact, I got slightly peeved whenever people focussed on photos and physical resemblances and so on. To me it wasn't something that was important. But it was quite amazing to see a little bit of a mirror image.

Neil appeared to define physical resemblance as similar facial characteristics, or perhaps body shape and stature. Some participants acknowledged that whilst the child conceived by DI might not look like his/her father, by adopting his mannerisms or interests the child comes to resemble his/her father. This reflected Snowden, Mitchell and Snowden's findings that once children conceived by DI were old enough to exhibit their father's mannerisms and characteristics, they become like their social father's progeny (1983:141). Diane commented that although her son, Scott, did not look like his social father, in many ways he was very like him. Diane's mother, Marion, corroborated this perception:

KH: In some families, people talk about inherited looks or character traits. What sort of talk is there around Scott?

Marion: Well, it's a bit of a laugh, you know, because often you see Chris's traits coming out in him. And sometimes you forget and just say, "Oh, he's like his father" or whatever, you see, because he's got a lot of Chris's mannerisms. He obviously is picking up things. He's got Chris's interests, as in fishing, etc., and right from babyhood. So that, you know, when you say that, you just would not be able to pick out the fact that he's not Scott's biological father. That's absolutely honest.

Diane's brother, Philip, also thought Scott was very like his father, to the extent that he continually forgot his nephew's DI origins. However, unlike Philip's mother, who said that Chris liked being told that Scott was like him, Philip said he felt he had to be careful not to offend Chris by saying something like "He's so like you Chris". This illustrates a tension between the perceived need to construct likeness on the basis of the 'facts' of reproduction and an acknowledgement that physical relatedness can be as much a metaphor for social relations as a statement of biological fact (Barnard, 1994:786-7).

Other family members, who knew about the child's donor conception, said they felt they had to be wary of making comments about likenesses between the parents and the child. Frances, an aunt of Joe and Ella's three sons, said about visiting them shortly after a son's birth:

Frances: We were petrified that we were going to say something in front of Joe. When we went up to see the baby, we sort of thought, right we'd just better be careful what we say here, because normally when you see a baby, you say, "Oh, doesn't he look like his father, or doesn't he look like his mother?" So that's what we were really, really worried about (she laughs).

Like Philip, Frances perceived the need to acknowledge physical relatedness on the basis of the biological 'facts' as she knew them. In contrast, comments that the child resembled both the mother and father appeared to be used by some kin as a strategy to give primacy to the social father over the donor. Like Marion, who perceived likenesses between Scott and his father Chris, Joanne, the maternal grandmother of Madison, commented that her granddaughter had her daughter Belinda's "little round face" and her son-in-law Richard's ears. She said she could see "a bit of both" of the parents in her grandchild. She explained this by drawing an analogy between her niece's experience of adopting a child who was "the spitting image" of her adoptive mother. This in turn draws on public narratives about some people being "lucky enough to adopt a dead ringer". In this way, physical resemblance between parents and children can be attributed to random phenomena, rather than strictly to heredity. Other family members, however, who were relatives of Madison's father, could not see a likeness between father and daughter, and resisted colluding with other family members who insisted on there being a resemblance. Christine, Richard's sister-in-law, commented:

Christine: Richard and Belinda told us about the donor and the physical attributes that he had and those sorts of things and it seemed... he sounded very like Richard and I thought that that was really good. I was really hoping that she would be very like Belinda, but I have to be honest and say that I don't particularly find her that way...which surprises me. But seeing Belinda's father, I actually find Madison quite like him... I've told them that, because Belinda has put me on the spot and said, "Who do you think she looks like Christine?" because a lot of people say that she looks like Richard, and I completely disagree with it.

The differences in these family members' perceptions might be explained partially by what others in the study said, that people see different things in others (or see what they want to see). It could be argued that, as mothers-in-law of infertile men, Marion and Joanne actively construct physical resemblance between their sons-in-law and their children conceived by DI to confer on them the status of father and to lessen the possibility of an asymmetry existing between their daughters and their husbands. In Christine's case, the refusal to construct physical resemblance between her brother-in-law and his daughter might be explained by her belief that the 'biological' and the 'physical' can be taken as essentially synonymous and applied to the facts of

reproduction (Barnard, 1984:787). At the same time, it might reflect the feelings of ambivalence that appeared to exist between these two couples which stemmed from the fact that Jeremy, Richard's twin brother, was fertile while Richard was not.

Commenting on physical resemblance is a way of expressing social acceptance of the child as the offspring of the two parents. This can even be extended to lesbian parenthood, a generally unfamiliar form of parenting, where it is not possible for both parents to be genetically related to the child. Petra and Jennifer had this to say:

Jennifer: One of the most interesting ways we find we're really going to be accepted is like, my dear grandmother who said, "Oh she looks a little bit like you Jennifer and a little like you Petra." And then she goes, "Oh, that can't be can it!" And that's a sign of incredible acceptance, I think, when people look at Olivia and actually...

Petra: ...see me. And people do, I mean at work people have said, "Oh she'll probably have curly hair because you've got curly hair." One woman said that to me and then a day later came up and said, "Oh, look, I'm so sorry. You probably thought that was so offensive." I just thought it was lovely, but I mean, you know, they just haven't got the hang of it.

This scenario reveals that identifying physical similarity legitimates the parent/child relation. It creates social connection through the discourse of physical connection.

Resemblance between children and parents or their kin is not static or constant, and some parents mentioned that likenesses shifted and changed over time. Making comparisons is more feasible for those with a known donor, who are therefore familiar with the physical characteristics of both parents. Sophie and Ria said:

Ria: Well, she looks like herself at the moment.

Sophie: A mixture of both of you. She's got Derek's eyes. She's got amazing blue eyes [she goes to get a photo of their daughter Lydia].

Ria: Oh yeah. I've asked him before if he gets as many compliments about his eyes as she does about hers, because they're definitely the Taylor's [Derek's family] eyes...When she first came out, our midwife said she definitely looks like Derek, and then she did look like Derek in the early days, and then she sort of changed to look like me, and then she goes back to looking like him.

Some families with anonymous donors commented that their child must resemble the donor in some way because he/she had characteristics that were foreign to the maternal family. Kathy noted about her daughter Melissa:

Kathy: And when she was born, I remember thinking, 'goodness me'. She was quite an olive [skinned] little girl, and she's got dark brown eyes. And I'm not an olive person. My father is a blond man with blue eyes.



According to Kathy, Melissa had asked her where her thick blond hair came from because both her parents and her sister had fine hair. Thus, she had noted how she did not resemble other family members.

Some paternal grandparents expressed regret that they could not see a physical resemblance between the child conceived by DI and their sons who were the ‘social’ fathers. The views of these grandparents contrast with those of maternal grandmothers who actively construct physical resemblance between their sons-in-law and their grandchildren. Jim, Erica’s grandfather, made the following observation:

Jim: She’s a dead ringer of Alice. And that’s good, that’s good. But you don’t see any of Peter in her, and that’s natural, and I think that’s a little sad.

When first visiting her donor grandchild in hospital, Joan was acutely aware that her granddaughter was not genetically related to her side of the family.

Joan: When I first saw her at the hospital and her other grandparents were there and they were saying, “Oh, I can see a likeness to someone or other”, then I felt envious. It was definitely with envy. I did feel envious...and I suppose they can see a likeness in the family, which I never will in my family.

For Joan, the lack of physical resemblance between her and her granddaughter, based on the lack of a genetic connection, appeared to create a distance between her and her granddaughter. The lack possibly symbolised a diminishing of the contribution to the child’s character than Joan felt she could make. This highlighted the importance of resemblance in the bonding process. Illustrating this point, in gestational surrogacy, racial difference between the surrogate and the commissioning parents is sometimes viewed as a positive factor because the lack of physical resemblance is seen to facilitate the process of separation between surrogate and child (Ragone, 2000:66).

The tracing of a relationship on the body was also symbolic of continuing the life of a loved one. Derek, the father of Sophie and Ria’s child, had been particularly close to his late mother, and welcomed the opportunity to reproduce elements of his mother by ‘fathering’ a child. He said:

Derek: And I want to see her genes go on. My brother, you know, he’s not going to have children, and my step-brother... my father had another wife before my mother. So, my mother’s genes weren’t going to be carried on. And it’s interesting, you know, I see little facial movements that I attribute to my mother when I look at Lydia.

Seeing resemblances between family members may in part be related to the gender of the child. For example, Caroline, the mother of two daughters, Toni and Lucy, said that she was pleased that she had daughters rather than sons because, in her view, it was more possible to see a resemblance between mothers and daughters and fathers and sons. By implication, this meant that by having daughters, she was less likely to have to make connections between the donor and her children.

Caroline: I suppose in one way I was quite pleased that we had girls, because I think that if I had had boys I would be looking at the boy thinking, "Oh, you must look like your biological father." Whereas I can look at the girls and I can see myself in them, whereas I couldn't see myself...oh you might be able to see it in a boy, but I think that the male traits come out a lot more. So, in a way, I suppose I'm really pleased we had girls.

Caroline acknowledged that before her daughter was born, she thought a lot more about what she might look like, but later she had thought little about the donor, except in some situations. She recalled:

Caroline: But once Toni started developing her own little personality the thought just never entered my mind what the donor was like, except when she was screaming in the middle of the night, and I used to think, 'What is this donor like? Is he a maniac?' [she laughs]

Caroline appeared to attribute her daughter's 'different' (and in this case unpleasant) behaviour to her 'other' origins (i.e. to the donor). This is similar to a situation, discussed later in this chapter, where a parent might address the co-parent referring to a misbehaving child as "*your* child". Toni's aunt, Mandy, agreed that her nieces looked very much like their mother, but she also wondered where their very curly hair originated.

Mandy: They do look like Caroline, yeah. Funny, because, as I said, people would say, "Doesn't that look like Mike?" [the father] and I used to go [she makes a face indicating doubt or uncertainty]. But they do look like Caroline when you see baby photos. But they've both got this curly, curly hair, so that's the only thing I wonder about...mind you Mike's got curlyish hair...But they don't really look like Mike. They don't have the freckles and the ginger tinge like Mike. And I remember Caroline laughing, saying "At least we won't have ginger-haired kids!" (she laughs) or something like that, because Mike does have a red tinge to him. And they're really tight curls, like very...Caroline had curly hair as a baby, but not like they have.

While Mandy pointed to a possible 'benefit' of having DI: avoiding having children with 'ginger' hair, Pippa remarked that their daughter might have inherited better looks from the donor than she would have from her father, Sean. She said:

Pippa: [The donor] must be reasonably good looking, because Elspeth's quite cute. I think she'll be better looking with him than with Sean's family (we laugh). I think we've got a cuter child (she laughs).

KH [to Sean]: How does that make you feel?

Sean: Mm. You haven't told me this before *dear*.

Pippa: Because they've got quite angular features, you know, very pointy features, particularly Sean's mother. So, I think Elspeth's probably lucked in [sic] actually (she laughs).

This is reminiscent of the ways in which DI could be used for eugenic purposes, or to ensure that the child had socially-valued physical and/or intellectual attributes. For example, one sperm bank in the United States was set up for those who wanted sperm from Nobel Prize winners. Recently, a website was set up to sell the oocytes of models, for those who would pay the price to have (hopefully) a beautiful child. This idea is embedded in the Enterprise Culture where "the child is literally - and in many cases, of course, joyfully - the embodiment of the act of choice" (Strathern, 1992b:34).

### **The child conceived by DI as 'special'**

Like adopted children whose parents often tell them that they are 'special' and purposefully 'chosen' (Snowden and Snowden, 1984:111), many children conceived by DI are perceived as 'special' by their parents and family members. For example, they can be considered 'special' because they were born after the considerable 'heartache' associated with infertility, and effort on the part of the parents (Snowden and Snowden, 1984:76-77). In light of the characterisation of children conceived by DI as 'special', a maternal grandmother said:

Joanne: But it's the old story isn't it? What you haven't got, or can't have, when you do have it, it's more special. You know, it's like that with everything isn't it? If you are suddenly able to have something that you thought you couldn't have, it's got to be better.

Joanne drew on a public discourse about how people always value more what they can not easily achieve, or what they have been able to achieve after 'beating considerable odds'. As previously discussed in this chapter, some parents are particularly appreciative of becoming parents after experiencing periods of infertility, and the time and effort involved in the DI process. This appreciation possibly partly explains research findings that suggest that the quality of parenting in families who

have children through assisted conception is higher than the quality of parenting in families who conceive without assistance (Golombok et al, 1993).

When asked if they thought of the twins as 'special', Jane and Steve said:

Steve: Um, at this age and stage I do.

Jane: I do. I think because I'm really so protective of them. It's because of how they came about, and it would be very difficult to replace them.

Steve: ...That's right, we're blessed with what we've got - two lovely children. There was always those risks and everything of things going wrong, you know, an unknown quantity.

Steve implied that his current perception of the twins as 'special' could change over time. This possibly related to the fact that he was estranged from the children of his first marriage. That Jane saw the twins as 'special' was connected to a perception that at her advanced maternal age, they would be difficult to replace.

Several parents told their children they were 'special' as a way of mitigating any possible negative consequences if they were perceived as 'different' because of their DI conception. Haimes (1998:55) has suggested that the perception that children conceived by DI are 'different' is a characterisation as 'other'. This, she claims, derives its cultural significance from "the awareness that in most Euro-American societies, it is not a trivial point to be conceived using the gametes of someone other than the adults raising you as your parents" (Haimes, 1998:55). Diane and Chris had told their son Scott, who was conceived by DI, that he was 'special'.

Diane: [It's important] to give him life skills to be able to cope with it, like the self-esteem thing and all the rest of it, so that they don't feel that they're different, or... if they do feel different that it's in a special way rather than a negative way.

Chris: Like he quite often, when he's been naughty, he'll tell you he's special (he laughs).

Diane: That's something we've always... right from a little baby eh... and the grandparents are the same. They've got lots of other grandchildren but I'm sure that he's probably the favourite, even though they wouldn't say it. They're just so attached to him aren't they?

The concept of Scott being 'special' was shared by extended family members and reinforced in their conversations. So, Scott was deliberately constructed as special. His maternal grandmother raised the issue of Scott's 'specialness' in the context of

encountering his paternal grandparents, with whom they had not talked directly about Scott's DI conception.

Marion: I remember meeting them when we were on holiday at one stage and we had Scott with us, and um, they actually said to us, you know, as he skipped out of our car to see them, "He's a very special little boy." And I think that's what we all think.

Scott's paternal grandparents' alleged characterisation of Scott as 'very special' appeared to be both a way of acknowledging the 'different' means by which Scott came into the family, and communicating to the maternal grandparents their total acceptance and appreciation of him. When asked to explain what constituted this sense of his being 'special', Marion said:

Marion: He's our second grandchild, and our first one of course is very, very special to us. But, because of the hard work to get Scott, and Scott is a very, very appealing little fellow, very normal...can be naughty and all the rest as well. He's very special to us, and we've had a tremendous amount of input into him, as Diane probably has told you. You know, we look after him a lot, of choice, rather than...you know. She works two days a week, but we ask if we can see him far more than the two days a week. He's probably very special because of the fact we've seen a lot of him, because we've been involved in the whole programme, in that Diane will come and keep us fully informed, but our...we've now got about five [grandchildren]...but I've got to admit, number one and Scott, though you try not to make a difference, are very very special.

Some parents and family members suggested that their child conceived by DI was 'special' in some way, but this was not necessarily related to how they were conceived. Sandra and Allan said that their children were set apart from others more by the fact that they were triplets, rather than by the nature of their conception. Sandra said:

Sandra: That's probably been more of a focus since they have been born, you know, they still get people saying "the triplets", which we're not particularly fussed on, but we'll never get away from it completely. So, that's where their focus is... if they're going to have a focus on something, then it's quite possible that it would go more that way than the other really.

Similarly, as discussed in Chapter Three, for Joe and Ella, Joe's father's response to William, their eldest son, was shaped by his status as the first grandson who 'carried on the family name', even though he was not related to his grandfather 'by blood'. They suggested that the grandfather perceived the birth of a first grandson, no matter his genetic ties, as 'special' in that it constituted a symbol of his family's continuity. When asked if they thought of their nephews as 'special' in some way, Matthew and Julia, the paternal uncle and aunt of Joe and Ella's three sons, had this to say:

Julia: In the beginning. The situation has changed though. I mean we don't treat them any differently to any of the other nieces and nephews.

Matthew: No. Not at all.

Julia: We don't see them any differently. They're not any more special than any of the other family.

Matthew: No they're not special. They're special to Joe and Ella, but to us no...

Julia: They're just...

Matthew: Our nephews, and that's it.

Other parents and family members who had initially characterised their child as 'special' said that they had begun to resist using the word in relation to their child. Patricia and Neil commented:

Patricia: I have to confess that when Tracey was little and I would say things like, "Yes, you are special to me." And she'd pick up on that and feel really important that she was very special. And, I felt concerned that I might have been putting too much weight into her being so special to us that it might create a barrier for her, that she was special and should be protected and looked after carefully, and handled carefully and things like that, and that that would be a barrier amongst her peers....children would just sort of notice when something is different with another child, and then it becomes that much harder for a child to enter into the group. So, I've stopped using that language with Tracey in that way, because I didn't want her to take on too much that she was too special.

Neil: I don't see anything wrong with that language. Ah, I don't think it's any different really than other families... their children, I think, are special to them.

While Patricia had stopped telling her daughter that she was 'special', in case it set her apart from her peers, Neil countered that this form of characterising children was common to families more generally.

Like Patricia, Sarah, who had written booklets for her children to tell them how they came to be part of their family, said that she now had second thoughts about referring to them as ESPs (Extra Special Persons). She said:

Sarah: When we wrote the books, we wrote Extra Special Person, but that was a philosophy going through. You know, I said to Charlotte, we had another special nice man that helped us, because we want him to be held up here [on a pedestal] but we try not...we don't try to make out that they should feel that they're special because we couldn't have kids. I mean, we don't make them feel that they've got a responsibility because we couldn't have kids. So, you know, we try to balance it with all that. And since then, probably if I rewrote the books, I probably wouldn't write that they were extra special people, or special persons.

Sarah indicated that she was aware that discourses that frame DI shift and change over time. It is also interesting that Sarah refers to herself *and* her husband when she said,

“we couldn’t have kids”. In light of the fact that Sarah and Tim did have children, and Sarah had experienced pregnancy, this illustrates her acceptance of the definition of *couple* infertility.<sup>6</sup>

### **The missing genetic link: the issue of ‘asymmetry’**

Critics of third party reproduction maintain that the separation of genetic, gestational and social parenthood weakens the bonds of kinship and lineage which are central to individual and societal stability. In response to such criticisms, Lauritzen (1993:74) contends that people should not just assume that a genetic connection is constitutive of parenthood. As previously discussed, however, the strength of the pervasive view that biological kinship is somehow foundational to family ties and kinship inevitably has implications for families who have conceived children by DI, particularly in relation to the meanings attached to concepts such as ‘fatherhood’, ‘motherhood’ and ‘parenthood’. The lack of a genetic tie between fathers and their children in these families is often framed as creating an ‘asymmetry’ or imbalance that has implications for family relationships (McWhinnie, 1996; Lauritzen, 1993; Baran and Pannor, 1989; Snowden and Mitchell, 1981).

Kathy was aware of the missing genetic link between her ex-husband Joel, and their daughter Melissa. She said:

Kathy: Yes. There was always that imbalance in there. I was always mindful of... I always wanted Joel to have a close relationship with Melissa, but then I realised I had to leave them alone to have their own relationship.

KH: But you felt that he bonded well with her right from the start?

Kathy: Yeah, he did indeed. He probably was a lot less complex than me. Mind you, men are. They think one thing at a time (she laughs).

Other women thought that their husbands might have found it more difficult to bond with their child because of the lack of a genetic link. When I asked Mary and Brendan if they were aware of any imbalance in their relationships as a result of having children this way, they said:

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<sup>6</sup> Infertility is generally defined in terms of a couple’s failure to conceive after twelve months of unprotected, regular sexual intercourse. Within the functional category of the infertile may be included some who are fertile; that is, people who are apparently able to have children with other partners and may already have done so (Dickens, 1990:24-25).

Brendan: Hasn't worried me, but I don't know about her [Mary].

Mary: No. Oh, sometimes I sort of feel as if he doesn't relate to them as well as I do. But that might be...[pause]

KH: Might be a "man" thing?

Mary: Yeah, yeah.

Brendan: Yeah, I think it is. I think a mother is always closer to her children than a male. Not always... yeah.

Mary: And particularly when I first had Jason. I think Brendan found it really hard to relate to him, but a lot of men do when the first baby's born anyway. You know, you become very protective, and that's something, you know, a tiny wee baby... but I don't know whether I was over-protective because we'd waited so long, perhaps, and perhaps left him out a wee bit with it, or whether he found it a bit harder because it wasn't his, you know, and it took him a while to bond. I think that, um, that that might be what a normal male finds. I'm not sure. But, I think as the years have gone on, you know, that he relates to them as well as any Dad....

[To Brendan] You did find it a bit hard when I first had the children, and people said, "Oh congratulations" and all this, you know, and all that stuff. I think he did feel, you know, "Oh it's not really mine, but I can't really tell you that."

Brendan: No I didn't at all. Who told you that rubbish?

Mary: Well, that's how I sensed that you were feeling.

Brendan: No, not at all. No. It didn't worry me at all.

What emerged in this conversation was Mary's projection onto Brendan of *her* awareness that the children were not genetically connected to him. This suggests that these were issues for Mary signalled in her reference to Jason as not Brendan's child. As the interviewer, I asked the leading question about gender which was prompted by information from other interviews when both men and women suggested that men often found it difficult to relate to newborn babies.

The experience of the lesbian couples in this study provides an interesting comparison to the initial parenting experience of heterosexual couples like Mary and Brendan. Sophie, the partner of Ria and Lydia's non-biological mother, said that because she was a woman, she expected to be able to bond with their baby in the same way as Ria did. They had this to say:

Sophie: It's been really hard, because Lydia didn't bond to me nearly as quickly as she bonded to Ria, purely because she was being breastfed by Ria and Ria was her primary caregiver really. I wasn't there all the time. And being a woman I think I took that harder, because women's emotions are a lot more sensitive.



Ria: We were both shocked when it started to happen. I guess we both went into it thinking two women, we will give and receive the same affection, but it didn't happen like that.

Sophie: No, she still goes through phases, like sometimes she just doesn't want anything to do with me, she just wants to be with Ria. And that's fine, but it is hard. And I know that after the weekend it'll be totally different because I spend so much more time with her.

Ria: It happens like that in any family. A man and a woman.

Sophie: That's right. Mum's the special one.

As two women who chose to parent together, Sophie and Ria sought to challenge normative assumptions about the traditional model of the two-parent family based on the biological model of reproduction (Dalton and Bielby, 2000). The two women expected to establish an 'equal' and similar relationship with their child from the start but Sophie, who was in paid work, found it more difficult to bond with Lydia because she did not breastfeed her,<sup>7</sup> nor could she spend much time with her during the week. In her study of lesbian couples' transition to parenthood, Reimann (1997:155) found that the experience of biological motherhood, especially breastfeeding, created a unique bond between the child and the birth mother. In the absence of biological ties, cultural support and legal security, co-mothers were motivated to form unique relationships with their children through regular interaction, shared child-care and child-rearing (Reimann, 1997:155, 167). Sophie and Ria explained their experiences of shared parenting by drawing on their knowledge of heterosexual parenting, the model of family that they were in fact resisting. The situation also illustrates the problems all couples have when one parent is more involved in child-care, but both want to be equally recognised as parents.<sup>8</sup>

Petra indicated that an asymmetry had developed between her and her partner, Jennifer, because she did not share the role of breastfeeding. She said:

Petra: I sometimes wonder if I feel less of a woman.

KH: In that you haven't borne the child?

Petra: Yeah, it's been fascinating to watch Jennifer's body change, and she can do some amazing things, and I don't know whether I can do them or not.

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<sup>7</sup> Concerned about her problems with bonding with Lydia, Sophie had sought advice from a gay man working at a child development unit who had advised her to take off her top when bottle-feeding, so she had skin contact with the baby. Sophie claimed that this seemed to help with the bonding process.

<sup>8</sup> See Lupton and Barclay (1997:119-141) for discussion about discourses and experiences in relation to negotiating fatherhood and men's relationships with intimate others, including their children.

KH: In what way?

Petra: Well, breast-feeding is an amazing thing to do, and giving birth is an amazing thing, so there's part of me that...so that changes, you know, she's done this amazing thing and I haven't.

In their national lesbian family study, Gartrell et al (1999:365) found that some co-mothers expressed frustration and feelings of exclusion during breastfeeding. Both Sophie and Petra struggled in a way they had not expected to negotiate a role as an equal co-parent with the biological mother of the child.<sup>9</sup> Petra said that her experience as a female secondary care-giver had raised some questions around general assumptions about gender. She said:

Petra: There are some interesting revelations about gender roles, if you are the female parent of a child who is not the mother. I'm finding that fascinating. I come home in the evening. I want to sit and do nothing. I get really stressed. I mean, I just...sometimes I'm turning into a man! It's disgraceful. It's really interesting; being the second carer is a really interesting role, and I think sometimes it's put onto gender and it's not actually to do with gender. [To Jennifer] We talk about it a lot, don't we?...

The best way to support someone who is the primary carer is to allow them to be the primary carer. However, that automatically disempowers me, so whereas I'm perfectly capable of taking the initiative and if I have Olivia on my own and she doesn't need breast-feeding, I can do everything for her, absolutely fine. When Jennifer's had her all day, I tend to defer to Jennifer around what needs... that can come across as dithering, as not being very clear, as being, you know, a 'useless father': "What shall I put her in? What shall I do?" I do it, and I do it because I'm deferring and because I feel more disempowered...and so I make an active point now of...at the weekends, I care for her as much as I can because that way I'm in charge, it re-empowers me. It reminds us both that I can do it, we can both do it.

Petra was fascinated to find that her behaviour was similar to that of fathers who, as secondary care-givers, were often described as 'useless' when it came to looking after babies. She suggested that men may be 'useless' because they are less likely to be primary care-givers. Secondary care-givers need *time* to exercise their autonomy as care-givers. If you are a secondary care-giver, your partner mediates and controls your parenting. Both Sophie and Petra reported experiences as co-mothers that indicated the way in which gender-based attributions and understandings about provider and care-giving roles are also an element of parental roles in lesbian families (Dalton and Bielby, 2000:40). The experiences of these lesbian couples, who are more explicit about the impact of being pregnant and breastfeeding than are heterosexual couples, raises the question whether what might be ascribed to being a

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<sup>9</sup> Gartrell et al (1999:365) found that most lesbian couples considered themselves equal co-parents, but when asked to name factors most strongly implicated in mother-child bonding, 50% of couple

non-genetic parent when couples use DI might also be attributed to being the secondary care-giver.

### **The missing genetic link: “They’re my children, not yours”**

In some cases, a feeling of asymmetry between the parents of a child conceived by DI was accentuated or invoked in stressful or adversarial situations such as arguments relating to other aspects of their lives. Other research has shown that the knowledge that the child was conceived by DI can be used by one partner to ‘hurt’ the other (Snowden and Mitchell, 1981; Baran and Pannor, 1989). Illustrating this point, Jane argued that she had a greater ‘claim’ to their children than her husband Steve.

Jane: To be quite honest, there have been a few times in the past where I sort of felt, well these are really *my* children, and felt quite annoyed about a couple of things. I suppose because I’m the mother and you [Steve] being a second time parent, and me having to go back to work with the children quite early, there was a bit of...

Steve: There was resentment there.

Jane: There was a bit of resentment, yeah, from the beginning, because we had a really expensive house...more expensive than this one...and we got caught when everybody else did with the house...you know...the prices dropping.

Steve: It was a promise that she would never have to go to work. And it never came through.

As further evidence of an imbalance between them resulting from the missing genetic tie between Steve and the children, Jane claimed that Steve often alluded to some of the children’s less ‘appealing’ characteristics as coming from her side of the family. Jane felt she could not in turn ‘blame’ his side of the family for the existence of some of their traits.

For Carla the feeling that her daughter was hers and not her estranged husband’s was accentuated by marital breakup. Carla, whose husband Ben left when Justine was five months old, said:

Carla: I was really disappointed that he hadn’t been at the insemination that I got pregnant at, and that’s been something that’s stuck with me, and particularly when he left, it was like, “this is [the nurse’s] and *my* baby now, because you weren’t even there”.

While Ben had shown some reluctance to continue trying to conceive a child by DI, according to Carla, he had been a ‘model’ and attentive husband during her pregnancy. She did not attribute their breakup to the DI, but to a number of factors,

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respondents named time spent with the child, and 32% said biological connections were most

including Ben's alleged mood disorder, and to the difficulties she had encountered giving birth and breastfeeding the baby. Snowden and Mitchell (1981) contend that while many DI practitioners claim that most couples who have a child by DI are in stable marriages, which are often enriched by the experience, some inevitably fail. For many of these marriages, the fact that a child conceived by DI is present appears to be irrelevant, while in others, it is an ostensible cause of failure or is used by one partner to hurt the other (Snowden and Mitchell, 1981:47).

Some couples suggested that having children, in and of itself, no matter how they were conceived, could aggravate existing problems in a marital relationship. Henry and Prue said:

Prue: I just think having children, full-stop, can aggravate problems. It wasn't the fact that they were donor. I don't think that's ever been a problem [a query in her voice].

Henry: I felt alienated at one stage. I felt scared that Prue would pick up the kids and walk away from me, saying, "they're all mine." I felt I could lose everything. It's just a fear, you know. But that's gone away. Probably I dwelt on it, because the people we knew [who had had DI], they split up too. It was sort of like if you had donor kids you'd break up. It was like this was the fear.

Prue: I certainly think that the breakups... I've got another friend in [another town] with donor children, and she's just split up from her husband, but I don't believe it's got anything to do with having donor children. It's other problems. Probably problems that had been going on before they had those donor children.

Some researchers have argued that the separation/divorce rate amongst parents of children conceived by DI is not as high as that of the general population (Snowden, Mitchell and Snowden, 1983; Amuzu, Laxova and Shapiro, 1990). Adair (1994:87-88), however, cites Norwegian research by Benvold, Sioberg, Skjaeraasen, Kravdal and Moe (1989) that found that the separation rate amongst parents of children conceived by DI did not differ from other groups of the population.

Despite some of the complexities and ambiguities existing for parents of children conceived by DI in relation to some feeling of asymmetry between them, most couples said they thought of the child as *their* child. Belinda and Richard, the parents of a daughter conceived by DI, said:

Belinda: ...as far as I'm concerned, it's *our* baby. Richard's problem too! (she laughs).

Richard: You know, you think about it at times, I mean we've never said it, and you could turn around and say, "Oh, she's a little ratbag" or something. You know "there you go, she's *yours*" sort of thing, but I mean...

Belinda: And he could blame me. "She's actually *yours*" (she laughs). But the thought's never come up.

Richard: You know, no, that's just cruel isn't it?

Richard and Belinda implied that they would never claim their daughter as anything but *theirs*, though the thought of doing otherwise had apparently occurred to them.

### **Uncertain fatherhood**

The 'asymmetry' that is perceived by some couples to exist in their relationship because of the missing genetic link between the father and a child conceived by DI appeared to have implications for some fathers' perceptions of their role as 'father'. In social and legal terms, the father of the child produced as a result of DI is the consenting husband or partner of the woman who was inseminated and bore the child. In New Zealand, the Status of Children Amendment Act 1987, states:

Where a married woman becomes pregnant as a result of artificial insemination and she has undergone the procedure with the consent of her husband (a) the Husband shall, for all purposes, be the father of the child of the pregnancy, whether born or unborn; and (b) any man, not being her Husband, who produces semen used for the procedure, shall, for all purposes, not be the father of the child of the pregnancy whether born or unborn (Status of Children Amendment Act 1987 (Cwth), s.5).

The law therefore considers the social father and not the genetic father to be the father, in all senses of the word. Similarly, according to Smart (1987), English law on paternity does not strictly follow the biological relationship between men and children. The biological relationship, although recognised as important, has not been a major factor. She argues that in English law, the relationship between men and children has been mediated by marriage, and paternity is dependent on proof of marriage rather than proof of fatherhood (Smart, 1987:101).

Most fathers of children conceived by DI claimed to think of, and relate to, their child as 'their own' child. Many were very positive about the strength of the bond they felt existed between them and their child. For example, Chris, the father of Scott, said that he "couldn't wish for a better child." Some fathers, however, noted that they perceived that their relationship with their child was qualitatively different from what it would be if they were genetically linked to the child. The lack of a

biological/genetic tie appeared to make the relationship seem somewhat tenuous on one level, even if, on the social level, they felt they had bonded well and had a good relationship with the child. When asked about the missing genetic link between Peter and his daughter, Peter and Alice responded:

Peter: I feel a little bit threatened by that, but just in terms of you know, perhaps the longevity of our relationship or the tenure of my kind of involvement...somewhere way down the track, it's hard to know isn't it?

Alice: It was pretty difficult...

Peter: It may always be that the bond between Alice and Erica is stronger than it could be with me, you know, that's a concern I guess.

Alice: I don't know. I mean, I think you're just observing from the outside. Your bond with her seems as strong as any other father.

Peter: Yeah. No, no no. It's not whether or not that's actually; it's just my perception.

Peter distinguishes between what *is* and what he is constructing as a possibility. He juggled with two conflicting discourses: that the bond between a parent and child is diminished by the lack of a genetic tie; and what 'really' matters in terms of the tenure of the relationship is the strength of the social tie between the parent and child. Snowden and Snowden (1998:41) contend that 'DI fathers', as 'intentional' but not genetic fathers, might at some later date wish to sever ties with the child conceived by DI, having grown to regret their 'intention'. In contrast, Peter appeared to be suggesting that his daughter might somehow feel a weaker tie to him than to her mother, with whom she has a biological tie that he does not share. This situation invokes the pervasive cultural notion that biological ties, unlike social ties, are permanent, unalterable and cannot be severed (Snowden and Snowden, 1998:41).

Golombok et al (1993) argue that while it was suggested in the Warnock Report, 1985, that a missing genetic link between the child and a parent might constitute a threat to the relationship, the results of their study do not support this contention. Their findings suggest that genetic ties are less important for family functioning than a strong desire for parenthood (Golombok et al, 1993:21). Another study, which compared the functioning of 'DI families', 'IVF families' and families with children conceived without assistance, found that the quality of father-child interaction in IVF

families was higher than that in DI families<sup>10</sup> (Brewaeys et al, 1997:143). The authors concluded that the results of their study suggested that parents with children conceived by DI have to deal with a number of difficulties associated with the use of a donor, which parents of children conceived using IVF do not. They suggest that more research is needed to examine the long-term psychological effects of DI on family relationships (Brewaeys et al, 1997:148).

Like Peter, Steve, the father of twins conceived by DI, expressed some uncertainty about his position as father of his children.

Steve: I feel a very close bond, but there's still the realisation at the light of day as to where it is...you know...where I stand. But I don't think it's diminished my love or care for them, and the same for Jane [his wife].

Awareness of the child's genetic origins appeared to be more acute for fathers in particular social contexts or at particular times in their child's life. Andrew recalled the times when he was least and most conscious of not being his daughter's genetic father.

Andrew: At birth time...there were no thoughts at all in regard to her being a donor child. That wasn't part of my thinking at all at that time. Those thoughts go way, way to the back of your mind. They only start coming back as the child starts growing up, like starting to walk, and developing their own personality, that you start thinking again about the donor insemination...from my point of view. Annie would be different because she's still the maternal parent, and fundamentally that doesn't change. ...It's no different from Annie having a prior arrangement with someone else and having children. We hear songs about it now.

Andrew acknowledged experiencing conflicting feelings that his children were 'his' and yet they were not because of the lack of a biological connection to them.<sup>11</sup> He likened his experience of being a father of children conceived by DI to that of a stepfather.

Some fathers claimed to feel that they related better to their children once they had grown out of the baby stage, but they did not relate this to their having been conceived by DI. Henry said:

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<sup>10</sup> When examining children's perceptions of their relationship with their fathers, however, no differences were found between fathers of children conceived by DI and fathers with 'naturally' conceived children. This led the researchers to conclude that there was no clear evidence that the lack of a genetic link between fathers and their children conceived by DI might account for these differences (Brewaeys et al, 1997:143).

Henry: I do a lot more stuff for the kids now that they're self-propelled, yeah. When they were much younger I felt that I could only do so much with them because they were fragile little entities and I didn't want to... yeah, my world's out there [on the farm] and they can go into it now.

Another father, whose two children were conceived using different donors, said that he found it easier to relate to his daughter than his son because of their differing personalities.

Brendan: I just sometimes find it a little bit hard to relate to Jason. I can relate to Natalie better than Jason. I think that Natalie and I have similar personalities, whereas as Mary says, he's a little bit deeper, more emotional. The problem is, you see, he's not sports-orientated, and we've been trying to get him into sports. He's just... he's really an academic. He's not into sports at all. So I've found that hard, because I believe kids should be involved in sports. I mean, he's played cricket for a while, but he's only very average, and he didn't really like it. He just got bored.

Brendan's claim that it was more difficult to relate to his son because he was quite unlike him raises the question as to whether the donor, whom they had no part in choosing, was quite different from Brendan. It could be argued, however, that many children have different inclinations and aspirations from their parents. Although I did not formally interview children for this study, I had the opportunity to speak briefly to Brendan and Mary's children, Jason, aged 12 years, and Natalie, aged 10 years. They had been told two years previously how they were conceived. When I asked them if this had implications for their relationship with their father they said:

Jason: I just don't really care. It's only a very little part of my life, so it doesn't really matter. He's still my Dad. We're still like related emotionally and all that.

KH: What do you think Natalie?

Natalie: Oh, the same.

To Jason and Natalie, their emotional tie to their father was more significant than the fact that they were not genetically related. This supports Lauritzen's argument for defining parenthood in relational terms (1993). He suggests that if persons are forced to choose between a genetic connection and a social/emotional connection, they tend to opt for the social relation (Lauritzen, 1993:94).

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<sup>11</sup> See Chapter Four for further discussion of Andrew's conflicting perceptions about his relationship to his children.



While positive about their relationship with their child who was conceived by DI, some fathers, who had talked to their child about the donor, appeared to wonder how they stood in relation to the donor in the child's mind. Neil said of his eldest daughter, who was nearly 5 years old:

Neil: Tracey now feeds back to me that, "Dad you're the most specialest Dad" or something like that, and I'd say, "Well, how many Dads have you got?" and she'd say, "I've just got one." And what's that thing she's saying now about one hundred Dads?

Patricia: She wouldn't be able to keep up with them all.

Neil: If she had one hundred Dads. So, one's enough.

Neil appeared satisfied with the idea that his daughter thought that one dad was enough. Like Neil, Paul, said that he talked to his daughter, Elise, aged 9 years, on a number of occasions about her donor conception. Elise was present during part of the interview with her parents, and Paul asked her:

Paul: How do you...you've sort of got two Dads though didn't you say to me?

Elise: Yeah.

Paul: What am I? Which one am I?

Elise: *First* daddy.

KH: First daddy?

Elise: Yeah because he's mostly my daddy.

KH: And what sort of daddy would the donor be?

Elise: Half.

According to this account, Elise thought of the donor as a 'half Dad', presumably because of his genetic contribution to her conception. This raises a number of questions connected to children's construction of family and kinship (Pryor and Rodgers, 2001; O'Brien, Alldred and Jones, 1996). Pryor and Rodgers (2001:128) argue that children's understanding of family changes over time, and that in middle childhood, biological ties become more salient. Pryor and Rodgers (2001:129) also comment that there is a great deal of diversity in who constitutes family for children. This raises the question whether the donor, as a 'half-daddy', would be considered by Elise as part of her 'family'? It also raises the question of how the concept of 'a donor' is presented to children conceived by DI, and how their conceptualisations of

donors might change over time. The question also arises as to whether the term 'Dad' or 'father' should be used in connection with the sperm donor.

Whereas some men expressed ambivalence or uncertainty about some aspect of their relationship with their children conceived by DI, many mothers and grandparents of these children were very positive about the relationship between fathers and their children. The question arises as to whether this may be attributed in part to initial concerns that they had about the father bonding with the child, and a desire to support the infertile male, whom they perceived to be in a somewhat vulnerable position. Belinda said this about her husband Richard's relationship with their daughter:

Belinda: Richard can get her to crack up, like, really crack up, laughing her head off. And he can do the stupidest things like kiss her around the neck and nobody else can do those sort of things, and he can toss her around and she'll squeal with delight. Anybody else does it; she won't do it. They've just got their own little bond. They just seem to click.

Like Belinda, her mother Joanne spoke in glowing terms about her son-in-law's relationship with Madison.

Joanne: Yes, she's got a good father, and I'll keep reminding her (she laughs). Oh he is. He's wonderful to her. There's certainly, you know, I just look at... and I think, even if my boys are fathers, I don't think they'll have as much compassion for their daughter as Richard has for Madison.

The maternal grandmother of Scott, Chris and Diane's son, had this to say about the strong bond between father and son:

Marion: If you could see Chris with that little boy, you know, we forget [his donor origins]. ...He's a proper dad...he'll come in, particularly when Scott was little and he'd be the one who'd be skiting off the new word or whatever, you know? There's just no question. I've got complete faith that Chris probably most of the time forgets what his origin was, so there you are (she laughs).... There's just no question in our minds as to whether Chris's got any questions or regrets or anything because he's just too... he just could not pretend the way he is. He takes him out fishing for hours on end and this sort of stuff... all the things that dads do. In fact, he's one of the best dads I've seen, and that is honest.

Marion's comment that Chris was such a good dad that nobody would ever guess that no genetic tie existed between father and son raised the common assumption that a genetic tie is a prerequisite for men to bond well with their children. Chris's parents, Doug and Sharon, were similarly positive about Chris's relationship with his son. Doug said:

Doug: As far as Chris goes, he's just a born father... a parent. Have you met him?...If the donor was of the ratbag type [he chuckles], I would be very, very disappointed. But then again, with the upbringing that Scott is going to get, and the love and attention, and what have you, there's no reason why he shouldn't turn out tops.

Doug hesitated to use the term 'father' in relation to his son, but he nonetheless spoke highly of his skills as a parent. He drew on a discourse about the importance of both genetic inheritance and environment in determining personhood anticipating that, even if the donor were a "ratbag", his grandson's excellent upbringing would probably override any such inherited tendencies.

The powerful cultural theme of the importance of 'blood ties', however, emerged for Chris's mother who had some concerns that their grandson might eventually wish to form a relationship with the donor, and that this might threaten Chris's relationship with his son. She said:

Sharon: Probably that is the fear in the back of my mind. I don't, um, perhaps it's in the subconscious frame that, yes, I could feel that he might want to take more of his own father, like from 18, the hurt Chris would go through. That would probably be my mothering instinct<sup>12</sup> for Chris's side, I would say.

Sharon drew on a discourse about the importance of biological/genetic connections between parents and children in articulating the fear that her grandson might be drawn to the donor as his genetic 'father'.

For couples who were no longer together, the relationship between the child and the father appeared inevitably somewhat tenuous and sometimes problematic.<sup>13</sup> Like most fathers and mothers after separation, Carla and Ben had to face the often difficult tasks of negotiating and renegotiating their family relationships (Pryor and Rodgers, 2001:205). Couples interviewed for this research who were no longer together had had to arrange for shared care of the child. Carla said that while Ben did not want to have their daughter, Justine, to stay while she was still very young, they

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<sup>12</sup> The concept of 'maternal instinct' is problematised by sociologists, such as Gittens, who argues: "That women can conceive and bear children is a universal phenomenon; that they do so by instinct is a fallacy. So is the notion that they always raise them. From the moment of birth motherhood is a social construction" (1993:67).

<sup>13</sup> Because I was unable to interview men who were divorced or separated from their partners and no longer living with their child who was conceived by DI, only the mothers' perspectives are discussed here.

now had an arrangement where she stayed with her father on alternate weekends.

Carla said:

Carla: He didn't have her for the first two years and I got really depressed and ended up in [hospital]. And so Children and Young Persons (CYPFS)<sup>14</sup> [intervened] because they felt that Justine's life was in danger, because I was so depressed. And we had a huge family meeting and he had to take some responsibility for Justine, so to start with it was actually imposed on him, because he really didn't want to have her. But now that we're out of nappies and we sleep all night and we're not a problem, he absolutely adores her. And he looks forward to the time and enjoys it, and will pop in sometimes.

As Justine's legal father,<sup>15</sup> Ben was required to share in her care. Carla perceived him as a 'fair weather dad'; at the same time, she believed that Ben and Justine had developed a good relationship over time.

Also separated, Joanna said that her husband, Roger, had left her after each of the two children were born, and that now they were permanently separated. In her view, he had not adjusted well to parenthood, although he had initially wanted to have the children. She said:

Joanna: He left when Todd was three months' old. He left and went to Aussie, and then we followed him. Then I discovered he had an affair over there, so we came back here. He seemed to go off the rails after I had the child...sort of had these affairs after I had them. Someone said he's probably insecure. It's like he got sort of jealous. It was funny, I mean, he wanted the children probably more than I did, but then when we had them he sort of used to say, "You go to work," because he wasn't working at that stage, "and when you come home you spend time with the baby, and then you're doing things around the house and never spend any time with me." There was sort of quite a jealousy thing there. I suppose because we'd been seven years with just the two of us, yeah. You've sort of got to change your ways.

While I am not qualified to comment on the psychological issues related to marital breakup after infertility, both Carla's and Joanna's experiences raise the issue of 'dysfunctional' parenting following infertility. According to Hammer Burns (1990:178), a number of psychological studies of parenting after infertility suggest that "dysfunctional parenting following infertility may result when expectations of the anticipated rewards of parenting are less than the actual rewards". Joanna claimed that although the children saw their father regularly, Todd did not have a good relationship with his father and had refused to stay with him on occasions.

<sup>14</sup> The Children and Young Persons and their Families Service, currently known as Child Youth and Family, is the New Zealand government department that works with families to protect children, ensure that children in need are secure and cared for, and help families maintain and strengthen their child-rearing role (CYPFS, 1997:5).

<sup>15</sup> This indicates that legal fatherhood can be differentiated from social or biological fatherhood.

Joanna: Todd has just got a thing at the moment, if anything happens to me, he doesn't want to live with his Dad. He brings it up himself. Him and his Dad have not had a very good relationship. They've only just started this last six months. [His father's] doing a parenting course which is really helping, because he's got a real bad temper and used to scare Todd. And Todd doesn't like getting close to his Dad because his Dad's been in and out of his life quite a bit. They haven't had much of a bond anyway, and I think he's just...I think because my grandmother and my two uncles had just died around the same time, and I think he was feeling a wee bit insecure – “What happens to me if Mum dies? Where do I go?” and he didn't want to go to Dad's. He still doesn't. He'd rather go to his friend's place and live.

While Joanna raised questions about the future tenure of her children's relationship with their father, Kathy contended that Melissa's relationship with her father had been affected by his recent remarriage. She said:

Kathy: He remarried last year [1997] and she has not, probably from three months before the wedding, been keen to go [to stay at his house]. I've encouraged her to go across. When she gets there she's okay, and he does a lot of talking with her as well. We speak to each other on the phone. If anything it's been the one thing that's actually literally made us speak to each other. She's always had problems with it, and I think at that point, I don't know, you could talk to her about that, I'm sure she realised at that point that the blood connection wasn't there, and she just had been grappling with it in her own right, and not said anything openly about it. Because he had taken on board his partner's 16 year old and now says, “this is my other daughter.” I think this would have made her think “where am I in all of this? Not even connected.” I actually said that to him at the time.

Kathy appeared to attribute Melissa's insecurities about her relationship with her father, at least in part, to the fact that they were not genetically linked. The question arises, however, whether she is projecting onto her daughter her own feelings about the importance of a biological connection between parents and children.<sup>16</sup> It is possible Melissa's concerns were more likely to stem from his remarriage, reconstituting his family and acquiring another 'daughter', all of which were likely to change the dynamics of her relationship with her father.

Like divorced or separated mothers, Ria and Sophie had some concerns about Derek's long-term involvement with their daughter, Lydia, aged 7 ½ months. Although legally he was not Lydia's father, Ria, Sophie and Derek all considered Derek to be the 'father' of their child, rather than the 'donor'. This contrasts with the results of Haines and Weiner's qualitative study of lesbian women who conceived by DI which found that most women did not define the donor as their child's father (2000:488). Ria and Sophie, however, said they did not see Derek on a regular basis. They said:

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<sup>16</sup> For a more detailed discussion of this issue see Chapter Three.

Ria: It's up to him how much he wants to have to do with Lydia, but there's also the concern that will it all go okay for the two of them? I just hope that she can get what she wants from him.

Sophie: Mm. Because he's very good at not following commitments, and things like that.

Ria: We don't want to ask for a commitment from him, and I think that we would just like to see that he's responsible and consistent with her.

Sophie: We're quite open to what he's wanting. If he wants a small amount to do with her life, that's fine, but if he wants more, that's good too. But I don't want him to decrease his involvement.

Ria and Sophie were caught between not wanting to ask Derek to take on the responsibilities of a legal father, and wanting their daughter to have a 'father' who would act responsibly and consistently towards her. Their situation illustrates that the nature of the family they created by self-insemination is somewhat unpredictable, and demonstrates how lesbian parents define, redefine and debate their family characteristics (Haimes and Weiner, 2000:495). Ria and Sophie were concerned that their child's 'needs' were met in her relationship with Derek. Similarly, in their qualitative study of lesbians who had become parents through DI, Haimes and Weiner found that arrangements made with the donors were shaped by their developing views on how to meet their child's needs (2000:484). The authors also contended that donors were located amongst a number of interwoven and changing considerations for the women (2000:479).

When asked about his expectations of his involvement with Lydia, Derek said:

Derek: As time goes on, and Lydia develops, I feel that I'm going to have to be there more and more, whereas initially, I try and be there quite a bit. I haven't seen her for almost three weeks at the moment. That's the longest it's been, and it's been hard, but it's got a lot to do with me being busy and also I've had a really bad head cold that I didn't want to take around. So, there's those sort of things, but I'm really missing her. But as time goes on, I can see her coming to stay with me, you know, for the weekend, or maybe in school holidays, she might stay for a week or something if I get time off. It's for me to make it available to her.

Derek appeared to be juggling work commitments and the desire to have some on-going contact with Lydia. This tension illustrates the process whereby Derek is constructing himself as a particular type of 'father': not only a biological father but also a social father, albeit not a co-habiting or a legally-recognised father. This suggests that there are more than the three categories of father suggested by Eichler: biological and social father (often considered the norm); biological father only; and social father only (1996:291). Derek's expectation that he would see more of Lydia as

she grew older reflected some of the previously discussed views of heterosexual fathers, who had more to do with and felt they related better to their children once they were beyond the baby stage. That he had not seen Lydia for three weeks because of illness and other commitments highlights the contingency that surrounds his involvement as a father. It also illustrates Dolgin's argument that while women are generally thought of as becoming mothers 'naturally', men become fathers by choice (Dolgin, 1995:51).<sup>17</sup> Later in the interview, Derek said that he expected to be involved in major decisions about Lydia's life, including her education, and he planned to attend her naming day on her first birthday.

When asked if their relationship with Derek had changed since Lydia's birth, Ria and Sophie said:

Sophie: No.

Ria: No. I do feel stronger towards him, more bonded to him, I guess. But friendshipwise, no, it's the same.

KH: Do you feel a bond because of the biological tie?

Ria: Yep. And I guess now that the child is here, there's a realisation that it is for life, and he is the biological father, so he's part of her life, for life. Therefore he's part of our life, for life.

Ria believed that a life-long bond had emerged between them as a result of procreating a child together. Derek appeared to feel a similar commitment to an on-going relationship with Ria, Sophie, Lydia, and other children they expected to procreate together. He commented on his relationship with the two women:

Derek: I feel that since this has happened, I now have two sisters. The relationship has changed dramatically. It's become an unconditional thing, and now that you're my sister, if a problem does arrive - I haven't seen any arise, but it's bound to arise - we're just going to have to deal with that. We don't turn around and walk away, we have to actually sit down and deal with it. I have a half-brother and a brother. And my relationship with the two women now is as strong as those relationships.

Derek suggested that Ria and Sophie had become akin to his biological relatives since Lydia's birth. He applied a family image to describe the social relations between him and the two women whom, he perceived, had become his 'sisters' through the process

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<sup>17</sup> Ria, Sophie and Derek planned to enter into a legal contract that defined their relationships, and rights and responsibilities vis-à-vis the child. According to Derek, Sophie and he would apply in the future for legal guardianship of Lydia. This illustrates Dolgin's contention that in the last two decades

of conceiving a child together, which illustrates the way people practice family description and construct family meaning (Gubrium and Holstein, 1990:10). This provided a potentially interesting framing for Lydia of her parents as siblings.

## **Conclusion**

The chapter has argued that families with children conceived by DI are not unitary. Like all families, they respond differently to issues that they confront: in this case, families respond to a particular set of issues that emerges as a result of conceiving a child with the help of a 'gift' from a stranger. In spite of the pervasiveness of powerful cultural images of conventional nuclear families based on biological ties, most parents perceived their family to be a 'normal' or 'regular' family. While DI brought with it particular challenges to confront, which might be different from those emerging for other families, this did not mean that their families were 'different' from a particular norm. Even if they were constructed as 'different' from 'normal', this did not mean they were abnormal or not normal. Parents thus generally avoided constructing a dichotomy between 'different' and 'normal'. Several parents pointed to the diverse ways of forming families in contemporary life. The concept of being 'different' was endowed with a variety of positive and negative meanings. If they acknowledged difference, it was in positive terms, such as being 'special', 'unique', or 'extraordinary'. Some parents acknowledged difference along a variety of dimensions, other than the origins of their child, such as family size, marital status, and in the value they placed on their children because of the difficulties encountered having them.

Perceptions of being 'different' were contingent and embedded in particular social and temporal contexts. Some parents felt 'different' amongst others who had had children conceived without assistance or had more than one child. Other parents were aware of being 'different' when they first had their baby, but this diminished after social ties had developed. Others were more conscious of having conceived by DI when the child's personality was more evident. For some parents acknowledging 'difference' was tantamount to being honest and accepting the reality of having conceived with the help of an anonymous donor. While some heterosexual couples

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courts have increasingly permitted adult family members to define their relationships in contractual terms (1995:47).



actively concealed their 'difference' from others, this was not possible for lesbian couples who acknowledged that they might be perceived as 'different' by others, but hoped that their parenting would become normalised as more gay and lesbian people became parents. One lesbian couple, who thought of themselves as 'normal', were occasionally reminded that others perceived them differently, raising the issue that self-perception of difference is at odds with the perception of others.

Talk about physical resemblance and difference between parents and children brought into sharp relief assumptions about relatedness based on biological/genetic ties in families. It also demonstrated that 'biology' is a cultural construction that is as much a metaphor for social relations as a statement about genetic fact. Comments about likenesses and differences between babies and their parents highlighted that it is common for people to trace relationships on the body whether or not a genetic tie existed (although this was often assumed). Remarks that babies resembled their mothers and not their fathers reinforced notions of an asymmetry in some relationships. Evidence of a strong physical resemblance to the mother, however, also served to establish distance and emotional boundaries between parents, their children and donors. Some parents and their kin avoided invoking discourses of physical likeness or difference, preferring instead to focus on the primacy of the social relationships. That the child was perceived as 'different' was not always attributed to genetic inheritance, but to general attributes of 'family', such as social positioning, or that families commonly have a child who stands out as 'different'.

Further illustrating that physical resemblance is not necessarily attributable to genetic inheritance, some extended family members, and maternal grandparents in particular, commented on likenesses (either facial features or mannerisms) between their grandchild and his/her father. The construction of physical resemblance suggests that this can be used as a strategy to actively construct a father/child relationship and to mitigate any perceived asymmetry in families with children conceived by DI. Relatives of the social father were more likely to resist constructing physical resemblance between father and child thereby giving primacy to the lack of genetic connection between them. This suggests that the lack of genetic ties is significant in some ways to the family members of the infertile social male. This raises some questions about whether family members of the infertile male might not, on some

level, accept the child conceived by DI as part of their ‘family’. That some paternal grandparents expressed regret about the lack of physical resemblance to their side of the family illustrated the importance of resemblance to the bonding process, and that physical difference can separate people rather than bestowing a sense of unity or belonging. In contrast to this view, some parents thought that a genetic endowment from the donor might have conferred on the child ‘better looks’ than he/she might otherwise have inherited.

The child conceived by DI was often conceptualised as ‘special’. This raised some issues about whether or not the characterisation of ‘special’ somehow singled out these children as ‘different’. However, in their conceptualisations of their child as ‘special’, parents sought to minimise the possibility of negative associations of being ‘different’. These children were perceived as ‘special’ for a number of reasons over and above the circumstances of their conception. Perceptions of the child’s ‘specialness’ changed over time: initially, the child might have appeared ‘special’ but, with the development of social relationships over time, they became ‘just part of the family’. Some parents who had told their child conceived by DI that they were ‘special’ or ‘extra special persons’ had later decided that this might construct the child as in need of special treatment and set them apart from their peers. This indicated that as the child grew the circumstances of their conception became less relevant.

The chapter explored the issue of ‘asymmetry’ in families with children conceived by DI. The missing genetic link between fathers and their children appeared to be more of an issue for some women than their husbands. Issues of gender and bonding emerged both for heterosexual and lesbian couples. Some women perceived that the lack of a genetic tie negatively affected the bonding process between father and child. Non-biological mothers in lesbian relationships raised the issue of the need for secondary carers to have time to bond with their child. For these women, being secondary care-givers who did not share in the breastfeeding of the child created an unexpected asymmetry between mother and co-mother who, as two women, anticipated an equal parenting partnership. In relation to this asymmetry, one non-biological mother raised the question of whether the notion of the ‘useless father’ was more attributable to being a secondary carer than to gender *per se*. This could, therefore, explain any bonding difficulties experienced by the father reported above.

The issue of asymmetry was invoked in adversarial situations or marital breakup when some women felt they had a greater 'claim' than their husbands to their children. On the other hand, some men responded by attributing negative characteristics in the child to the mother's genetic inheritance. Others feared that their wife might leave, taking the children with her. This illustrated the uncertainty surrounding fatherhood after DI for some men. While most men thought of their child conceived by DI as *theirs*, and stressed the importance of the social/emotional tie, some thought that the relationship they had with their child was qualitatively different from the mother's because of the missing genetic connection. These issues have implications for the quality of not only the father-child relationship but also the relationship between parents of children conceived by DI that need to be considered in the context of DI treatment.

Detracting from the issue of asymmetry, many grandparents and other extended family members highlighted the significance of the social/emotional bond that developed between fathers and their children conceived by DI, describing the relationship between father and child in superlative terms. This indicated that the strategies used by extended family members to incorporate (or potentially exclude) the child into the family or kinship network might have significance for family dynamics. Others, who drew on the discourse of the primacy of biological/genetic ties, raised concerns about the possible threat to the father if the child showed an interest in the donor.

Illustrating concerns about the tenuousness of social fatherhood, some women who were separated or divorced had encountered difficulties maintaining a relationship between the father and child and where social bonds were not strong, some had doubts about the longevity of the relationships. Uncertainty surrounds not only the relationships between children, whose parents are separated or divorced, and their social/legal fathers, but also those constructed outside the legal framework through self-insemination. Parents who conceive through self-insemination, with the help of a known donor, need to engage in on-going negotiations to construct forms of parenthood and fatherhood that ideally 'work' in the interests of the children thus conceived.

In sum, this chapter has argued that if one considers relationships both ideologically and as enacted, a standard 'DI family' does not exist. Instead, the chapter shows that parents, their children and kin all respond differently to sets of issues connected with conceiving children with the genetic contribution of sperm donors. Within these diverse families, perceptions of sameness and difference are embedded in social and cultural contexts that shift and change over time. Perceptions from the outside, and sometimes from the inside, might frame these families as 'different' because DI, as a method of conception, is relatively unknown and rare, and challenges dominant cultural understandings about the biological basis of family formation. Analysis of the interview material indicates, however, that people in these families, as in all families, are actively engaged in the processes of continual negotiation and re-negotiation of intimate relationships in the context of the fluidity and diversity of contemporary family life.

## PART FOUR

### **Conclusions**

## **Chapter Twelve**

### **Locating DI Experiences**

#### **Introduction**

This thesis has contextualised the use of donor insemination (DI) in Aotearoa/New Zealand. It has shown that people's experiences of conceiving a child through DI are located within a broad spectrum of discourses, practices and relationships. The context for DI experiences, among other things, includes the couple's relationship, their kinship networks, the fertility clinic, the donors and their actual or imagined relationships with children, as well as the legislation defining fatherhood. The research has also been carried out in a particular socio-political context, where children's 'right' to be informed of their biological/genetic origins is a dominant public and professional discourse. Interviews with parents took place at a time when most parents are encouraged to tell their children how they were conceived, and when donors indicate a willingness to be contacted. For some parents, however, the current socio-political context which advocates 'openness', sits in stark contrast to their experience at the time at which they conceived, when DI was provided under a cloak of secrecy, and they were given little information about their donors in order that they remain anonymous. As this study shows, anonymity in the current climate of information-sharing has on-going implications for parents and children who are unable to identify donors and remains a highly problematic aspect of the practice of DI.

Many of the potential problems regarding the inability to identify donors are not addressed in this thesis because I spoke to parents before their children reached adolescence, and therefore before many issues of identity come to the fore, and before some parents had begun the process of telling. This context has shaped what was discussed in the interviews and the analysis that has been offered.

The thesis has made a unique contribution to the field in that it includes interviews not only with parents, but also with members of their extended families and the health professionals who assisted them in conceiving. The thesis therefore has explored the way couples' experiences of infertility and their use of DI were located in interactions with their wider network of kin. The inclusion of the perspectives of extended family members in this study has provided distinctive insights into what it means to be part of a particular family. It highlights that children conceived by DI are not only born to their parents, but become part of an extended family network comprising individual relatives who themselves define what it means to be part of a family. This, in turn, influences the ways that family members relate to the child, which may or may not be determined by the meanings attached to the significance of biogenetic ties. Interviews with grandparents and aunts and uncles of children conceived by DI have drawn attention to what it means to belong to a family group and the ways that extended family members may include or potentially exclude children conceived by DI. The study has shown, that while some wider kin who knew of the DI conception expected to experience the child as 'different' from other children to whom they had a biogenetic connection, for most, the social bonding that occurred between them and the child over time defined the child as their relative and part of their extended family network.

Couples' experiences of DI have also been located in their interactions with fertility clinics and particular health professionals who adopted different subject positions vis-à-vis recipients in the clinical context. Analysis of the clinical context has highlighted recipients of donor sperm being located in a particular medical environment where their treatment is managed according to particular policies, protocols and quality control regimes, and where couples are urged to be 'open' with children conceived through the DI programme. In particular, this study has argued that DI can be conceptualised as the medicalisation of family building, and that the discursive practices of health professionals rework meanings of family and relatedness. The fertility clinic provides the context for the child's 'right to know' their genetic origins. The culture of the clinic and what the clinical staff advocate sets up the ways in which families and parents define what it means to have a child conceived by DI and how they will act. The fact that clinics recruit only donors who are willing to be identified sets up the potential for the identification of donors and possible social relationships

between donors and children in the future. Moreover, the practice of the gifting of semen and the role taken up by clinics as intermediaries between families and donors, for example in the exchange of gifts or letters, or in the 'matching' of donors and recipients, clearly demonstrates that clinical strategies that set up relationships between parties to the DI conception have a bearing on wider family relationships.

Analysis of interview material also has located families with children conceived by DI within a framework of discourses, practices and debates relating to ideas about families and kinship in contemporary western societies. The thesis has demonstrated how parents and their kin draw on notions of 'nature' and 'nurture', and discourses about biological and social parenting, to make sense of their experience of having children conceived with the help of an initially unknown sperm donor, who potentially might become known to them. The thesis has drawn attention to the many ways in which parents rework the biological/social dichotomy and manipulate meaning about relatedness. Parents work their way around biological primordialism by emphasising the power of social connection even as they use biological symbolism to define relationships that do not have a biogenetic component. This demonstrates that biology is usefully employed by parents of children conceived by DI as a metaphor for social relations and not just as a statement of biological 'fact' (Barnard, 1994).

While the themes of biology and social environment interacted in people's interpretations of kinship and family, some participants, particularly the family members of infertile males, placed greater emphasis on the importance of biogenetic ties. For some, the lack of a biological connection to the child meant that their perceived relationship to the child was qualitatively different from if there had been a biological connection. This presumably has a bearing on how family members will relate to the child, particularly when he/she is young and the social bond has not yet evolved. Family members, however, conceptualised the significance of biology differently. For some, the biological connection has strong implications for identity, and belonging to a particular family; for others, biology was significant in the context of medical or health issues only. For the latter, the social bonds created between loving parents and their children were constantly privileged over the significance over biogenetic ties.



The perception of families as primarily social units, rather than institutions based on purely genetic connections between parents and children was frequently challenged by participants in this study. While some participants expressed concerns that the lack of genetic connection led to uncertainty in terms of the quality or tenure of the father/child relationship, several parents referred to the diversity of family forms in contemporary New Zealand society, where, for example, divorce and reconstituted families are common. In this context, conceiving a child by DI, did not seem so unorthodox or 'different'. Similarly, lesbian-led families who chose to conceive by DI expected that their family form would become normalised as more same-sex couples became parents. This study has shown, however, that a tension exists between the liberal discourse about the acceptance of family diversity, and families through choice (e.g. lesbian-led families, sole parenting) and conservative discourses that support the dominance of the 'modern' family, and repudiate the creation of 'fatherless' families. Such diametrically opposed ideologies of family raise important questions about general societal understandings of what 'family' means and for the formulation of policy and practice in DI.

This thesis has also drawn attention to the different experiences of men and women participating in DI programmes. While the initial focus for most couples was the problematic, infertile male body, in the clinical context the inability to conceive was defined as a 'couple' problem. During treatment the focus shifted from the male body to the monitoring and surveillance of the female body. The thesis has therefore identified that constructing parenthood through DI is a gendered experience and that men and women respond to the issues as both individual gendered persons, and as couples. This inevitably creates complexity and often tension for couples with male factor infertility. While, in one sense, male infertility can be defined as a technical problem, this thesis has shown that it is a social problem for the whole family and possibly for others, such as workmates. The thesis has highlighted that a network of people are involved in negotiating DI in some way. It has therefore been about how having or not having sperm is located in complex sets of relations, ideas and understandings about the meaning of parenthood and 'family' more generally, and also in different understandings of biology and fertility.

### **Families and discourses of relatedness**

As a study of networks of relatedness in families with children conceived by DI, this thesis has been framed by discussion about changing families, family practices and kinship in contemporary western societies. The study emerges at a time of renewed sociological interest in family practices, in contrast with a prior focus on ‘the family’ as a static societal institution (Morgan, 1996; Smart and Neale, 1999; Silva and Smart, 1999). The new conceptual and theoretical interest in families emphasises human interaction, including gendered practices, and parent-child relationships. It emphasises relationships based on particular understandings of sexuality and the body. Fluidity and change in families are recognised and the notion of ‘the family’ as a unitary category is disrupted (Weston, 1991; Stacey, 1996; Coontz, 1992, 1999; Gittens, 1993; Smart and Neale, 1999; Silva and Smart, 1999). According to these social theorists, families can be created in different ways and, as a result, ‘the family’ has come to signify the subjective meaning of intimate connections, rather than formal objective ties based purely on biological or marriage ties (Gubrium and Holstein, 1990). Illustrating this argument, this study has explored the way that heterosexual couples with male factor infertility and lesbian couples have chosen to embark on the project of parenthood and forming families through choice and with the use of sperm from a donor.

Just as the sociological focus has shifted from ‘the family’ to families and family practices, social anthropological theorising about kinship has changed its focus from structure to practice and practice to discourse. Social anthropologists, such as Strathern (1992; 1992a; 1995), Franklin (1995, 1997) and Carsten (2000), are particularly concerned with issues about ‘nature’, ‘biology’ and the relationship between the ‘biological’ and the ‘social’. These authors destabilise the analytic opposition between ‘biological’ and ‘social’ kinship, highlighting that the boundaries between these concepts are somewhat blurred. The destabilisation of the analytical opposition between ‘biological’ and ‘social’ kinship is central to the conceptual and theoretical basis of this thesis. Analysis of the talk of parents and their kin about their subjective understandings about family connections and relatedness indicated that people draw on discourses that both construct and deconstruct the analytic opposition between the ‘biological’ and the ‘social’. This supports Edwards and Strathern’s

(2000) contention that a distinguishing feature of twentieth century notions of kinship in Euro-American cultures is the division and combination of social and biological 'facts'.

The shift in focus in social anthropological theorising about kinship has been attributed in part to Schneider's (1984) critique of the study of kinship and Eurocentric assumptions at the heart of anthropological study, and his subsequent contention that kin relations should be studied as an empirical question. In light of this recommendation, this thesis has explored the meanings that people in New Zealand attach to kinship and family. Disrupting the notion that biological connections between persons formed by procreation are the cornerstone of Euro-American thinking about kinship, this study has demonstrated that discourses about human connectedness exist that draw simultaneously on the power of 'blood ties' and the power of social connection. For example, in families with children conceived by DI, when talking about the father-child relationship, the nature/culture dichotomy was reworked by parents as a strategy for identifying social fathers as the sole fathers of their children (see Chapter Three, p.70). At the same time, relatives connected by what are conceptualised as 'blood ties' were seen to have a claim on one another and to be emotionally connected. For example, family members and friends expected mothers to feel 'closer' to the children they had borne themselves, than their adopted children (see Chapter Three, p.71).

Biological ties were seen by several people to foster closer social ties. This was particularly apparent in understandings about the process of bonding between parent and child. Some parents and their kin had concerns about the social father bonding with a child who was not genetically related to him. For others, a biological tie between the father and child was defined as *never* an issue, but also *less* of an issue as the social bond became established (see Chapter Three, p.72). This showed that social bonding has to occur between all parents and their children, but the significance given to the biological connection means that emotional bonds between people with genetic links are assumed and therefore perhaps facilitated by the biological. While some participants' talk gave primacy to 'biological ties', many parents and their kin privileged social ties over biological ties. The parents' intention to conceive and bear a child was perceived by many participants as the decisive factor in determining

parenthood. This suggested that the conception of a child is an expression of the love and commitment of two people rather than the desire to perpetuate particular genes (see Chapter Three, p.73). As a result, the social father was usually conceptualised as the father of the child in all senses other than having provided the genetic material for the child's conception.

Many parents in this study were themselves already embedded in complex kin relations before using DI to conceive children. Some had been adopted and traced their birth parents; others already had adopted children and maintained connections with their children's birth parents. Most parents recognised that biological ties have significance for human affairs, but that the meaning of the biological/genetic connection between their children and the donors was as yet unknown. The meaning of biological ties was complex: they were perceived as both significant and yet not significant. For example, Neil, a social father of two daughters conceived by DI, spoke about tracing his birth parents for his daughters' sake, in case they wished to trace their genetic father in the future, and also because, after discovering he was infertile, he experienced a sense of no genetic connection with the past or the future (see Chapter Three, pp.74-75). Biological ties were therefore conceptualised by some parents as representing the 'key' or a part of the 'jigsaw puzzle' of life. However, the parents of children conceived by DI also assumed their emotional tie was to the social or rearing parents.

Related to discourses of the 'biological' and the 'social' were the discourses of 'nature' and 'nurture' which emerged as interactive themes in parents' talk about what their children were like as people. Parents talked about the importance of both genetics and the environment in determining how their children were, but sometimes they privileged one over the other. Some parents contemplated whether their children's genetic predispositions were realised and reinforced by environmental factors, or emphasised the importance of genetics over the environment, or vice versa. Other parents suggested that genetic inheritance was not highly significant: the relationship that developed between parents and children was most important in shaping who they were.

Discourses of the ‘biological’ and the ‘social’ were often used simultaneously, highlighting the complexities and ambiguities that emerge for many people in families with children conceived by DI. One grandmother said that she felt proud of her granddaughter who was conceived by DI but, at the same time, she could not feel proud for herself because she had nothing to do with who she was genetically (see Chapter Three, p.90). Andrew, a father of two daughters conceived by DI also articulated this ambiguity when he spoke about his children being his and yet not being his (see Chapter Three, pp.91-92). Other family members raised the issue of the need to *try* to treat children conceived by DI as ‘true’ grandchildren. In contrast, other parents and their kin expressed little interest in biological ties or genealogy, and instead stressed the significance of environmental factors, and social ties between people (see Chapter Three, pp.95-98). Alternatively, for some parents and their kin, the significance of biological ties lay in the passing on of certain health-related predispositions, rather than in personal capacities or visual likeness to others in the family (see Chapter Three, p.96). Discourses of the ‘biological’ and the ‘social’, ‘nature’ and ‘nurture’, were therefore used both simultaneously and separately by parents in this study, sometimes highlighting how biology and social environments interact and, at other times, privileging one over the other.

The demonstration of the simultaneous use of discourses of the biological and the social in this thesis provides a wealth of empirical evidence that this occurs widely within families with children conceived by DI. This indicates that the concepts of biological and social relatedness play a significant role in how people define ‘family’ and kinship. In particular, the inclusion of the viewpoints of extended family members highlight that even if parents construct a particular meaning around motherhood or fatherhood to justify their use of donated gametes in the procreation of their children, their extended family members may hold a different, and perhaps conflicting view of their relationship to the child. Analysis of the narratives of parents and their family members suggests that strategies that rework meaning about family may be employed by other families where all children are not genetically tied to both their parents. This has particular relevance to the study of families in contemporary western societies where many are formed through choice, and possibly change form several times in the context of divorce and reconstituted families.

### **DI and the project of parenthood**

The thesis has located couples' experience of DI in the context of embarking on the project of parenthood in a particular, deliberative way. For most parents participating in this study, embarking on the project of parenthood was preceded by a 'journey' involving the discovery of male infertility and the experience of the shock and grief often associated with this knowledge. Many couples spoke of the personal difficulties associated with their infertility: that it was shocking, devastating and isolating. Some men spoke of the difficulty of coming to terms with their infertility and the issue of the lack of a satisfactory explanation for their infertility and the feeling of loss of control over their bodies and life choices. Drawing on sociological theory of narrative identity, the thesis has explored disruptions to people's narrative identity, and the way infertility stimulates 'replotting' and the crafting of alternative narrative identities (see Chapter Four, p.107).

Analysis of participants' narratives about their experiences of and reactions to infertility illustrated how infertility can be understood as a private trouble (Mills, 1963) in that parenthood is socially constructed as being important to a person's sense of biological and social completeness. The thesis has also shown, however, that infertility can also be conceptualised as a public issue because the values cherished by the public at large are not fulfilled by infertility, and because infertility is not uncommon (see Chapter Four, p.113). Estimates of the prevalence of infertility in western countries ranges between 10-20% (MCART, 1994:5). In New Zealand, it is estimated that infertility affects about 25% of couples at some time in their reproductive lives, and 3,500 new referrals are made for infertility services in New Zealand each year (Gillett, Peek and Lilford, 1995:9). That infertility is a public issue is also demonstrated in by the formation of the National Ethics Committee on Assisted Human Reproduction (NECAHR) and the significance of its role in determining the kinds of reproductive techniques and arrangements that are considered ethically acceptable in this country. Human Rights legislation and the consequences for fertility treatment practices, such as disallowing clinics to discriminate against certain types of person, is also an important component of the public issue of infertility and fertility treatment.

Discussion of issues connected with the politics of access to DI treatment also demonstrated that infertility and its treatment is a public issue, not only for married couples with male factor infertility, but also for de facto couples, lesbian couples and single women (see Chapter Six). The involvement of several participants in Infertility Societies as support networks at both the national and local levels was also testimony to the fact that experiences of infertility and fertility treatment are not only private troubles but also public issues (see Chapter Four, pp.115-116). Controversies about the cost of fertility treatment and the limited availability of state subsidies for those who need assistance to conceive also drew attention to the public issues surrounding infertility and fertility treatment (see Chapter Six, pp.201-207).

The unquestionable 'public' component of infertility and fertility treatment raises important questions and issues not just for those involved in accessing or providing fertility treatment, but for all people in contemporary western societies. Issues related to the formation of families and what is deemed to constitute an acceptable family form have wide implications for society as a whole. The secrecy that often surrounds the use of DI has limited public awareness, understanding and therefore acceptance of the use of donor sperm in the conception of children. This clearly has had negative consequences for those who find themselves in the position where they cannot expect to conceive a child without the assistance of a donor. It therefore seems important for the health and well-being of all people that the public become better educated about infertility and its implications for families, and are able to engage in debates around the use of AHR in contemporary New Zealand society.

This study has shown that for would-be parents with male factor infertility, the decision-making processes involved in considering the options for parenthood illustrated that choosing to conceive with the help of a sperm donor, was fraught with ambivalence and complexity. Analysis of the narratives of parents and their kin highlighted the significance attributed to the biological/genetic connection between parents and their children (see, for example, Chapter Four, p.138). As a result of this dominant discourse, many parents claimed that having a child 'naturally' was their first choice and that conceiving a child by DI was their second choice because it enabled a biological connection at least with the mother, if not the father, of the child.

By contrast, adoption was regarded as a third option if DI treatment was not successful (see Chapter Four, pp.122-124).

The project of parenthood embarked upon by parents in this study illustrated that self-identity is deliberative in high modernity (Shilling, 1993). The process of determining the 'best' method of becoming parents drew attention to the complexities and paradoxes associated with making this decision which were embedded in wider sets of relations. For example, many couples had rejected adoption as a means of becoming parents for a variety of reasons, including the difficulty of adopting in New Zealand, and the complexity of the social relationships entailed in open adoption. Some parents spoke about the possible harmful psychological consequences to a child of being relinquished by his/her birth parents. Others suggested that adopting an "unwanted" baby carried greater risks than conceiving a child under the auspices of medical science. While most parents claimed that a child conceived by DI would be more *theirs* than an adopted child, some relatives of infertile males expressed concerns about the potentially unfair 'bonding advantage' that the mother might have with a child conceived by DI, and therefore preferred the strategy of adoption (see Chapter Four, pp.125-127).

The thesis illustrated that decisions about alternative means of achieving parenthood are embedded in the social and cultural meanings attached to gametes and kin relations. For many couples included in this study, ICSI, a reproductive technology that enables men with very low sperm counts to become biological fathers, was not an option, at least when they conceived their first child. While most couples' first choice was to conceive a child biologically related to them both, after having conceived a child by DI, deciding whether or not to conceive by ICSI became a more complex task (see Chapter Four, pp.129-132). This was because it became important to consider the position of the child conceived by DI in relation to a possible sibling who was biologically related to both parents. Some parents wondered whether the 'full' biological child would be construed by others as what the parents 'really' wanted when, for them, the significance of the biological tie diminished after the development of a relationship with a child conceived by DI.



As a way of enhancing the biological connection between the social father and child, some couples had considered asking the infertile male's brother to become their sperm donor (see Chapter Four, pp.134-137). This prospect, however, raised a number of social issues and impediments related to cultural notions about people's potential sense of 'ownership' of children conceived using their sperm. Issues related to the difficulty of separating the concepts of 'father' and 'sperm donor' and, while not explicitly stated, the possible implications of an extra-marital relationship between the woman and her brother-in-law, were impediments to using brothers as sperm donors. This supports Haimes' (1993a) contention that gametes are charged with meaning and that social distance from an anonymous sperm donor was important for many couples using DI to conceive children.

Further illustrating the way that sperm are charged with social and cultural meaning, the thesis has drawn attention to the variety of ways in which sperm donors are conceptualised and the language used when referring to them. One social father referred to the donor as his children's "dad" (see Chapter Ten, p.358). Other parents used distancing language, such as "this person" or "this man" (see Chapter Ten, pp.363, 380, 383). Another father drew on adoption terminology and the discourse of the natural, referring to their donors as "birth fathers" or "natural fathers" (see Chapter Ten, pp.364-365). A mother referred to their donor as their son's "other parent", and assumed that the genetic connection might lead to an interest in a meeting between the genetic father and their son at some future date (Chapter Ten, pp.368-369). Women who were no longer married to their children's social father were more likely to refer to donors as their child's "father" (see Chapter Ten, pp.387-388), and to be positive about a social tie between the donor and their child in the future. This suggested that when the social tie is broken or diminished the biological assumes a more important role.

Issues relating to the language used to describe donors relates to Snowden, Mitchell and Snowden's (1983) "suggested nomenclature" which attempts to clarify the reproductive/parental roles of the parties involved in an assisted conception (see Chapter One, p.29). This study indicates that while many refer to the sperm donor, as "the donor", many use language that positions donors as 'fathers' which contradicts general taken-for-granted assumptions that people have only one mother or one father.

This highlights the difficulty in our culture of separating genetic connection from parental ties, and perhaps points to the need to introduce language into general usage that clearly differentiates the parental and gamete donor roles.

As further evidence that gametes are charged with social and cultural meaning, some social fathers were concerned about how they would react to having a child not genetically related to them (but to another man). Some couples stressed the need to come to terms with their infertility and their grief about the child they would never have together, before deciding to conceive by DI. A few women indicated that they had reservations about conceiving with another man's sperm: some were initially "revolted" by the idea, or perceived it as tantamount to "cheating" on their husbands (See Chapter Four, p.141). By contrast, others viewed DI as simply a means to an end. Some narratives about DI as a choice for conception drew on liberal discourses about the positive aspects of sharing gametes across families, while others referred to the Catholic Church's opposition to the intrusion of the third party into the sacred domain of marriage and human reproduction. For almost all couples, while DI was not perhaps the 'ideal' option, it was the best option in the circumstances and, despite some reservations about choosing to conceive by DI, the couples who participated in this research embarked on the project of parenthood as informed social actors and decision-makers.

### **The clinical context**

This thesis has also located the experience of DI in the context of the fertility clinic. It has highlighted the uniqueness of New Zealand as a small country with few fertility clinics, which together have adopted a policy that encourages information-sharing in DI. The study examined the discursive and relational strategies employed by two New Zealand DI programmes when establishing relationships between the parties to a DI conception, the processes involved in accessing DI treatment and recipients' negotiation of clinical worlds. The clinic is a context for the experience of becoming a 'DI parent'. While clinics exhibit some similarities in the organisation and operation of their DI programmes, variety between clinics also is evident. In this respect, 'the' fertility clinic carries out certain activities including gatekeeping, surveillance and quality control, that are required by RTAC, the accrediting body, but 'a' fertility clinic performs these activities in a particular way. For example, one clinic may actively

promote information-sharing, while the other may discuss with couples the advantages and disadvantages of ‘openness’. This raises questions about the practice of DI in New Zealand and the extent to which clinical practices should be regulated at the local or the national level. Some aspects of treatment protocols, such as the establishment of a donor register, are likely to be regulated at the national level through the implementation of future AHR legislation.

Interviews with health professionals demonstrated that relationships between the actors in the DI network are arranged around the principle of anonymity. This was complicated by the current policy of most DI programmes in New Zealand to recruit only donors who are prepared to be identified to DI offspring in the future. Central to the analysis of the establishment of relationships in the DI network were issues of trust, control, choice and rights. Participants indicated that trust was central to the medical encounter: health professionals had to trust that donors were telling them the truth about their lives, and recipients trusted health professionals to adequately screen and select donors for them (see Chapter Five, pp.154, 160). Issues of control, choice and rights were closely related and emerged in the context of donors’ rights to choose who can have access to their sperm, and recipients’ ability to choose a donor from a selection of donor profiles.

That DI offspring should have the right to find out identifying information about donors, should they wish to in the future, was a dominant discourse in the clinical context. This dominant discourse, it is argued, while not always adopted by parents, has a bearing on parents’ actions with regard to who they tell about the donor conception, particularly in relation to telling their child. In the interests of maintaining participant anonymity, the study does not specifically identify which clinic each couple attended. It appeared, however, that those who had attended a clinic that was directive in their advocacy of information-sharing and gave specific information about the sharing of age-relevant information were more likely to tell their child at a young age. This illustrates the way in which the clinical culture sets the context for the child’s ‘right to know’ their genetic origins. It also attests to the need for clinics to provide information that enables parents to develop the skills needed to pass on information that meets the child’s current level of comprehension. The study also points to the need to help parents construct ‘telling’ as an on-going

conversation, rather than a single event which can be perceived as a major obstacle to confront at a particular time in their lives.

In the context of fertility treatment, the thesis has demonstrated that choices and rights were constrained by those who had the power to define them. Health professionals had the power to choose the donors that are accepted onto the DI programme, and this in turn constrained recipients' choice of donor. 'Choice' was a discursive strategy employed by DI programmes partly to shift responsibility to the recipient couple for the selection of a genetic parent for their child. The process of 'targeting' particular categories of recipient was monitored and controlled by medical professionals who themselves had particular views on who were most 'deserving' of becoming parents (see Chapter Five, pp.163-165). In the case of one clinic in particular, health professionals and the donors they recruited clearly preferred to reproduce the traditional nuclear family and, as a result, sperm available to single women and lesbian couples was severely restricted. Some health professionals drew attention to the fact that children's 'right' to identify donors was tenuous because the ability to access identifying information about donors is not written into law, and donors could not be held accountable for their decision to be willing to be contacted by DI offspring in the future (see Chapter Five, p.162). This situation illustrated the tension that exists between competing rights discourses in the context of information-sharing about DI.

Attention to the talk of both parents and health professionals illustrated the prevalence of gatekeeping and surveillance in the processes of determining the suitability of prospective recipients for parenthood through DI. For most couples, the route to gaining access to DI treatment began with infertility diagnosis and referral to a fertility clinic. Several couples reported negative encounters with insensitive medical professionals before accessing treatment. These professionals were primarily concerned with 'treating' bodies and illness, and not with the social or psychological implications of their diagnoses (see Chapter Six, pp.189-190). Couples' varying experiences of accessing DI treatment illustrated the diverse processes by which identities are constituted and negotiated in particular settings. While DI programmes were traditionally set up to 'treat' male factor infertility in heterosexual couples, since the passing of the Human Rights Act 1993, clinics are no longer able to discriminate

against categories of people (such as lesbians, or single women) who seek to conceive using their services. Clinics, however, are legally able to exclude individuals who are not deemed to meet certain criteria that would indicate they were suitable for parenthood, particularly in light of considerations about the welfare of the potential child (see Chapter Six, pp.207-208).

The thesis has shown that once couples had gained access to DI treatment, they had to negotiate the shifting and changing identities of 'client', 'patient' and 'would-be parent' with clinical staff who adopt different roles and subject positions within the clinical setting. The negotiation of clinical worlds for DI recipients was multifaceted. All couples had to conform to clinical protocols which involved women's bodies being subjected to monitoring, surveillance and the clinical gaze, and the modification of treatment regimes with the objective of achieving a normal pregnancy within a statistically-determined timeframe (see Chapter Seven, pp.230-232). Couples began their experience of treatment by meeting with the clinical director who provided them with information about the organisation of the DI programme, treatment options and success rates. As well as meeting with the clinical director, recipients met with nurses who provided information about monitoring menstrual cycles and oversaw the inseminations. Clinical directors interviewed for this research indicated that recipients were generally required to attend one counselling session before beginning treatment.

This study supports the contention that the role of counselling in fertility treatment programmes is somewhat ambiguous because it involves elements of information giving, assessment, support and therapy (Daniels, 1993). Some health professionals reported resistance to counselling from some couples, particularly if they viewed the role as one of assessment or as a therapeutic injunction. Several couples participating in this study claimed that they did not see a counsellor while undergoing DI treatment. Some reported that nurses or doctors appeared to carry out an assessment and information-giving role (see Chapter Seven, pp.238-239). The counsellors I interviewed claimed that they usually saw couples more than once only if they had problems conceiving or were stressed by the treatment process.

Inconsistencies in whether or not couples attended counselling sessions and the implications for some who perhaps could have benefited from seeing a counsellor

raise issues for policy and practice in DI programmes. Some of the issues discussed by parents in the study raised questions about the possible need for on-going clinic support in relation to the psychosocial issues related to conceiving by DI. For example, comments made by some men indicated that they felt marginalised during the treatment process and this carried over into the ambivalence many experienced during the pregnancy and after the birth of the child (see Chapter Seven, pp.257-259). Interviews with couples indicated that, while men and women were together in confronting infertility and deciding to conceive by DI, they were also differentiated. This has important implications for the study of gender, and understandings about differing responses to infertility and embodied experiences of fertility treatment, which are highly pertinent to clinical practice in this area.

While infertility was constructed as a ‘couple problem’, men’s and women’s embodied experiences of infertility and treatment were quite different. The medical problem was diagnosed in the male, the women’s body was the object of treatment, and she became the biological and the social mother of the child conceived by DI. In contrast, the infertile male’s body was not ‘treated’ as such, although interviews with counsellors indicated that issues relating to men’s response to their infertility are discussed in the context of counselling (see Chapter Seven, pp.240-241). Ultimately, however, the men participating in this study were constructed as medically infertile, and through the processes of giving informed consent and, possibly participating in the insemination process, they became legal and social fathers, but unlike their wives/partners they can not claim to be biological parents of their children. This highlights the asymmetry between parents of children conceived by DI that can potentially be a source of tension or division within families.

Analysis of interviews with parents and health professionals demonstrated that after conceiving, couples’ pregnancies were constructed as ‘normal’ events to be monitored by other maternity caregivers. As a result, the relationship between the clinic and the couple formally ended, except in problematic or complicated cases. Nurses and counsellors maintained a caring role for couples who required follow-up and visited mothers and their babies after the birth to help celebrate their mutual success. This exemplified the gendered division of labour in the clinical context. Women generally provided care and emotional or practical support for clients in the roles of nurse or

counsellor, and men, as doctors and clinical directors, were more instrumental and outcome-focused in their approach. Having negotiated the clinical worlds of fertility clinics, and conceived by DI recipients then had to face alone the ambivalences, challenges and uncertainties associated with conceiving a child with the help of an unknown, but potentially knowable, sperm donor.

### **Negotiating relationships after DI conception**

The thesis has demonstrated that discourses about secrecy and disclosure and telling the child about their means of conception are highly significant aspects of contextualising the use and experience of DI. In recent years, the secrecy that has traditionally surrounded the practice of DI has been subjected to increasing criticism, particularly by psychologists, counsellors and social workers (Snowden, Mitchell and Snowden, 1983; Baran and Pannor, 1989; Daniels and Taylor, 1993a; Landau, 1998; Blyth, 1998, 1999). As discussed by these authors and demonstrated in this thesis, secrecy has been used variously as a tool to protect the parties to a DI conception, including the infertile male and the child, the donor and his family. The medical profession has also benefited from the secrecy surrounding DI in that it has protected doctors from public scrutiny and criticism. Secrecy has also served to protect the ideal of 'the family' (Haimes, 1990, 1993b). Critics of secrecy in DI have argued, however, that it is harmful for family relationships and denies those who were conceived by DI knowledge of their genetic origins which might have some significance for them (Daniels, 1995).

Analysis of the debates about secrecy and disclosure in the context of DI have drawn attention to the strong arguments for 'openness', or information-sharing between the parties to a DI conception in New Zealand, asserted on the basis that secrecy cannot be justified legally or culturally (MCART, 1994:71-92). The thesis has shown that fertility clinics state that children have a 'right' to know about their genetic origins, and therefore pressure is brought to bear on parents to be 'open' with family and friends and to tell their children how they were conceived. Chapters Eight and Nine focused on the complex issues of secrecy and disclosure and telling the child. Analysis of parents' talk about their patterns of secrecy and disclosure in relation to DI demonstrated that telling and keeping secrets is embedded in sets of social relations that shift and change over time. Negotiating what and when to tell was

shown to occur in the context of discourses about the family, the meaning of biological ties, children's rights, the stigmatisation of the 'different', and in relationships with clinics and donors. Decisions about whether and who to tell were shown to be decisions about who had the power to control the flow of information (Bok, 1984). It appeared that women were more likely to disclose information about their DI conception than infertile men, which raises questions about the gendered aspects of secrecy and disclosure. Difficulties arose for some couples when there was a tension between the perceived need for secrecy and the desire to tell. Social fathers who wanted to keep DI a secret appeared to do so out of a fear of social retribution, as a means of self-protection and to protect their children from the perceived stigma of being conceived using donor sperm. For the wives of these secretive men, however, the perceived need to keep DI a secret was oppressive, a source of distress, and a barrier to intimacy with others (see Chapter Eight, pp.280-282; 274-276). This suggests that attitudes towards secrecy and disclosure might be usefully explored in the context of counselling sessions in connection with DI treatment.

For most couples, the issue of non-disclosure was not so much to do with secrecy as it was about privacy and confidentiality. Many couples felt that having a child conceived by DI was their personal business and they did not wish to have to defend their decision to have a child in this way. Some parents did not disclose to others about the DI until they themselves felt comfortable with the situation. This illustrated secrecy as an adaptive process (see Chapter Eight, pp.296-301). It also showed that secrecy was part of the constant process of self-production. Stories people told about themselves, their actions and experiences, illustrated that being a parent involves being in the process of constructing selves from a selection of alternatives. Attention to parents' narratives demonstrated that disclosing private information to others was connected to issues of trust and intimacy. For those who had not disclosed to some family members or friends, deciding not to tell resulted in it becoming more difficult to tell over time because the failure to tell earlier raised questions about levels of trust and intimacy. Parents indicated that they did not tell those with whom they did not have a close on-going relationship. They also did not talk about it if those to whom they were disclosing opposed the use of DI.



Goffman's work on impression management and the management of stigma (1963) was shown to be highly relevant to the way that parents with children conceived by DI present themselves and their relationship to their children. Managing the impressions they give others, couples are strategic actors in the on-going process of crafting selves in diverse settings. While many had disclosed to family members and close friends, they chose not to do so in certain public settings, such as within antenatal groups and in the workplace (see Chapter Eight, pp.290-293). This indicated that information about identity in one situation can interfere with the maintenance of identity in another. Some women claimed that they would not tell those who might react in a judgemental way, or who would be made to feel uncomfortable by the disclosure (see Chapter Eight, pp.292-293). As another means of impression management, some couples chose to tell *some* of the story by implying that they had had IVF treatment, a more familiar and socially acceptable means of assisted conception (see Chapter Eight, pp.294-295). This also served to protect the male from the stigma of male infertility and reinforced the ideal of the traditional nuclear family.

Parents were interviewed for this research at a particular point in time in the history of DI, but also at a particular point in their career as parents. As strategic actors, couples operated with available discourses in diverse contexts, illustrating variety with respect to the strategies pursued and the subject positions that were taken up. Most couples operated with the discourse of the child's 'right' to know their genetic origins, but they took up a variety of subject positions in relation to when and how to tell their child. Like other research in the area of disclosure to children, this research indicates that disclosure is part of an on-going conversation and not a single event (Rumball and Adair, 1999; Hajal and Rosenberg, 1991). Some parents told their children from the beginning, drawing on the adoption discourse of the need for the child to think that their origins were "always known" (see Chapter Nine, pp. 326, 331-333) Other parents were waiting until what they perceived to be the 'right time' to tell, or when their child might understand the abstract concepts of biological and social relatedness (see Chapter Nine, pp.340-342). Yet others operated within the frame that the child would eventually know his/her origins, but had no specific plans to tell.

Parents participating in this study, who had told their children about their origins, crafted new discourses using the resources of the old. For example, they developed new scripts for telling based on traditional story-telling models, such as fairytales (see Chapter Nine, pp.332-335). The thesis has shown that parents who tell operate with a variety of competing or inconsistent discourses. These include: the harm caused by family secrets, and individuals finding out accidentally about their birth origins; the rights of the child to know their genetic heritage, and the possible significance of this knowledge for the development of a person's identity; the possible 'risks' of crossing the biological-social divide; and the potential disruption or disappointment incurred by seeking one's birth parents. These parents are not victims of their circumstances, but actively construct themselves as negotiators of their social worlds. As strategic actors, they manage the tension that arises between the competing discourses of the need for privacy, and the need for openness and honesty, particularly with significant others, to ensure the development of healthy, trusting, intimate relationships.

The parents of children conceived by DI who were interviewed for this study are living at a time of transition from the dominant discourses of secrecy and anonymity to discourses about the rights of children to know about their origins (and, for a few, the rights of donors to identify their DI offspring). As already discussed, the transition from a culture of secrecy to a culture of information-sharing in DI programmes has particular implications for families who were conceived under a regime of secrecy, but now confront the issue of the child's 'right to know' when this is not possible because donors did not agree to being identified at any time. The children of the parents interviewed for this research had not yet reached adolescence, a time when issues of identity become more prominent and when some of the parents planned to talk to them about their conception. These children will soon be reaching the age when many individuals who have been told about their conception might wish to discover more about their genetic fathers, or to make contact with them.

Over the past decade in New Zealand, fertility clinics have been recruiting donors who are willing to be identified in the future by DI offspring. It remains unknown whether many of these children/individuals will be interested in their genetic fathers and whether it will be possible for them to find the man who donated sperm for their conception. This aspect of the experience of DI for families presents an interesting

and challenging next stage in the study of the implications for all those involved in the use of DI: the couples, the children, the kinship networks, the clinics and health professionals, the donors and their families, and others who inhabit these intersecting networks of social relations.

Finally, this study has contributed to the sociological study of families in the context of the diversity, change and flux that marks contemporary western family life. While families with children conceived by DI can be perceived as 'different' in that children were conceived with the contribution of donor gametes, at another level, these families are merely one 'type' amongst many others. Like all families, these families engage in day-to-day practices that involve the negotiation and re-negotiation of familial and kin relationships. Unlike other families, these families respond to a set of issues related to the contribution of an unknown donor in the conception of their child. This study has shown that each family responds differently to these issues, illustrating that 'DI families' are not a unitary category. At the same time, a study of a particular 'type' of family and the issues associated with creating a family by DI has brought into stark relief the importance of acknowledging, understanding and addressing at all levels the issues that help people make sense of what it means to be part of a particular family.

## APPENDICES

## APPENDIX A

- Interview guides
- Information sheets
- Consent form

## **Interview Guide - Couples**

### **Background**

What led up to your having DI?

Reason for infertility

Response to knowledge of infertility

Contact with doctors/options suggested

Options considered (e.g. adoption?)

Access to treatment

Length of time involved before successful

Views/feelings about using donor sperm

### **The Process Of Choosing A Donor - Relations With The Clinic**

Anonymous/known donor

Choice of donor characteristics?

- any particular desires/concerns re donor

The clinic's process

Interaction with staff - who were they?

Advice/information from staff

Follow-up with clinic

### **Knowledge/Views About The Donor**

What do you know about him?

Do you want to know more?

Do you want to meet the donor or not?

Expectations re child's possible interest in donor in future

### **Views On Secrecy And Openness About DI**

Any advice from clinic re keeping it a secret or being open about DI?

Did you make any decisions initially as to whether you would tell others about the DI or not?

Do you think your child should know about his/her genetic origins?

How and when did you/would you tell your child?

Views of importance of this knowledge in development of identity

Discussions with child - issues that have emerged

### **Family Issues And Attitudes Of Other Family Members**

Effect of infertility/DI on couple's relationship

Any issues of asymmetry

How do you see your family in relation to other families?

Who makes up your extended family?

Who in family knows about it?

Who have you not told and why

Who else have you told/not told about DI?

What were the reactions of each of your family members?

Who are the people who have been most significant in terms of going through the donor process?  
(either supportive or not supportive)

Have your relationships with other family members changed as a result of having children through DI?  
How?

## **Interview Guide - Family Members**

### **Background**

How and when were you aware that [the recipient couple] were having a baby through donor insemination?

Did you have any involvement in the decision to use DI?

Did they discuss with you any other options for having a child - adoption, etc?

What knowledge did you have of infertility and treatment options available to infertile couples?

What are your attitudes towards or feelings about assisted reproduction?

### **Reaction to/involvement in the decision**

What was your reaction to the news that they were going to have a child that was genetically related to one but not both of them?

Did you discuss it with others including family members?

Did you think you would view a DI child differently from a child who was biologically fully theirs?  
- might the child be regarded as special in some way?

What were the implications of the birth of a child conceived by DI on the family as a whole?

How important are blood lines/biological ties in your family?  
- Talk about inherited character traits or looks?

### **Secrecy and openness**

What are your feelings about secrecy and openness in DI?  
- do you think the child(ren) should be told about his/her origins? Why?  
- do you think knowing one's genetic origins is important for the development of a person's identity?

Who have you told about the donor insemination?  
- has it come up in some particular situation?

Are there any people you would not tell and why?

### **Views on the donor**

What do you know about the donor?

What is your attitude towards the donor? Is he ever mentioned? Would you want to meet him?

Do you think donors should be available to meet their biological offspring if the child wants to meet them when they're older?

What would you think if the child(ren) wanted to meet the donor?



## Interview Guide - Health Professionals

Background on the clinic -

- How long have DI and ED programmes been in operation
- Numbers of couples being treated
- Reasons for choosing DI or ED
- Success rates
- Funding/costs involved
- Geographical area it serves

What is your role at the clinic?

How does a couple come to the clinic? Reasons for seeking this form of treatment.

What procedures does a couple have to go through to be accepted onto the programme?

Criteria for selection? Who would be turned down?

What is the role of counselling?

What sort of information are couples given about the programme/about having a donor child?

- advice re secrecy and openness
- implications for the child/for the family

What information are couples given about telling the child about their origins?

- availability of books

Choosing donors - known, anonymous

- do many choose known donors - how is this handled?

Do recipients have a choice of anonymous donor through the clinic? How do they choose?

Is the clinic involved in 'matching' donors and recipients?

How many children can a donor have through the programme? Is there a limit to the number of families that can access the sperm of one donor?

What procedures are in place to ensure donor anonymity?

How are records maintained so donors can be traced at a later date if the child wants to meet him/her?

What is the clinic's role as intermediary between the donor and recipient family?

Have there been instances of donor children meeting donors?

Do you expect that many children will want to meet the donors when they're about 18 or older?  
Grounds for this expectation?

Facilitation meetings between genetic half-siblings – clinic's role in this.

Does the clinic maintain contact with recipient couples after they have left the programme? Any follow-up?

## **Interview Guide - Health Professionals – Donor Recruitment**

What is your role in the donor insemination programme?

What is your involvement in recruiting donors?

What methods or recruitment are used?

What are the main obstacles to recruitment?

What is the clinic looking for in a donor? Are you looking for a variety of types of people, or is there a "typical" donor?

What sort of selection process takes place?

- criteria for inclusion (medical/social)
- criteria for exclusion

What are the main issues that are discussed in donor interviews?

What are the main motivations for a man to become a donor?

What is the role of the donor's partner/family in the process of his becoming a donor?

Do they tell their own children that they are donors and that there are genetic half-siblings out there in the community?

I understand that donors have a say in where their semen goes. What are the different categories of recipients that they have to choose from? What are the most/least popular categories?

What non-identifying information about the donor is passed on to the recipient couple?

Do donors expect to meet their offspring at some point later in their lives?

Have there been recipients who have sought to meet the donor?

How would this be handled?

How long do donors typically stay as donors?

How many donor offspring are born per donor?

What sort of on-going contact does the clinic have with donors?

## **Interview Guide – Health Professionals - Counsellor**

### **Background**

Role at the clinic

Length of time working there

Involvement in DI/ED/other

### **Recipient Couples**

Process they go through

At what stage of treatment do you see them?

Do you see referral notes from gps, etc.

How many sessions do they have/how long?

How many couples would you see per month?

What issues are discussed in the sessions?

- issues re infertility
- success rates
- other options - e.g. ICSI, adoption
- telling child of genetic origins
- secrecy/openness with others
- religious issues
- choosing a donor - anonymous/known
- expectations re children wanting to meet donor in future

Issues you are most concerned about in DI

Are any couples rejected/why?

The 'types' of recipient that you see - has this changed over time?

Views on treating single women/lesbian couples

Any other involvement in DI programme, e.g. donor recruitment?

## **Interview Guide – Lesbian Couple's Donor**

What led up to your having a child in this way?

What were your motivations?

Have you thought of being a sperm donor in a DI programme - would you want to be an anonymous donor?

Issues re fathering a child in this family situation

Do you have a partner?

Views re bringing up a child in your own home with your own partner?

How was the child conceived?

What is your legal position as the father of this child?  
- social father/biological father

What would be your rights vis-a-vis the child if anything happened to his/her mother?

What are your rights and responsibilities to the child?  
- access to the child  
- paying maintenance?  
- role in decisions about how child raised/educated

What is your arrangement with the child's mother and her partner?

What is your relationship with the mother/partner?  
- family get-togethers? Birthdays, Christmas?  
- discussions re what is in best interests of child

What is your role as the child's father?  
- how often do you see/have child to stay?

Do they call you 'Dad'?

What does the child call her mothers?

How has it affected your life to have a child?

Do you want more children?

Would you do anything differently in terms of the way you have chosen to parent?

Did you tell others about your decision to parent?

Who did you discuss it with?

Who would you not tell about it?

Reactions from others?

Who in your family knows about it?

What is your child's relationship with grandparents/extended family?  
- responses of other family members

How would you discuss your role in your child's life to the child?

Are there issues for the child of belonging to a 'different' type of family?

Do you think it is important for a person's identity to know about their biological/genetic background?

Issues re sexuality

- genetically/environmentally determined
- expectations re child's future sexual orientation

## Information Sheet for Participants

### The Use of Third Party Gametes in Assisted Reproduction: An Exploratory Study of the Implications for 'Family'

#### Information for Couples

You are invited to participate in the above-named research project. This is an exploratory study which looks at the effect on families of having a baby by donor insemination or donated eggs. I am interested to find out how you decided to use this form of conception, your experience of the treatment, your attitudes towards the donor, and the impact of using donor gametes on relationships within your immediate family, with the wider family and with others. I am also interested in how you deal with issues such as secrecy and openness, whether you intend to, or have informed your child of his/her genetic origins, and any on-going issues that emerge as a result of having a child conceived in this way.

If you agree to take part in this study, you will have one interview with Katrina Hargreaves which will take between 1-2 hours. This will take the form of a guided conversation. With your permission, the interview will be taped and later transcribed. Should you wish, you may receive a copy of the interview transcript for comment before it is analysed. The purpose of the interview is to gather information and not to offer advice or comment. However, if any issues or questions arise as a result of the interview, you can be referred to someone who will be able to provide information that may assist you. I recognise that this topic is private and personal. Therefore, you are encouraged to discuss only matters you feel comfortable talking about. You may withdraw from the interview or from the entire project at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this interview. I will be the only person having access to any identifying information about the participants in this research. To ensure anonymity and confidentiality, tapes will be kept in a locked filing cabinet, and at no time will the names of participants be revealed. Pseudonyms will be used in the publication of any of the interview material, and any identifying information will be changed to ensure complete confidentiality. Tapes will be erased or returned to you after transcription if you wish.

**Katrina Hargreaves** can be contacted at the University of Canterbury, telephone (03) 366-7001 ext. 7375. She will be pleased to discuss any concerns you may have about participation in the project. The supervisors for this exploratory study are:

Dr Jan Cameron  
Department of Sociology  
Private Bag 4800  
Christchurch  
Telephone: (03) 364-6186

Associate Professor Ken Daniels  
Department of Social Work  
Private Bag 4800  
Christchurch  
Telephone: (03) 364-6447

Jan Cameron has published books and articles on issues to do with families, and people's motivations to have children, or to remain childfree. With over 60 published papers on topics concerned with assisted human reproduction, Ken Daniels is an internationally-recognised researcher in this area. This project has been reviewed and approved by the National Ethics Committee on Assisted Human Reproduction.

## Information Sheet for Participants

### The Use of Third Party Gametes in Assisted Reproduction: An Exploratory Study of the Implications for 'Family'

#### Information for Family Members

You are invited to participate in the above-named research project. This is an exploratory study which looks at the effect on families of having a baby by donor insemination or donation of eggs. To this end, I am interested to find out your views on this form of assisted reproduction, the ways in which you perceive this practice has affected your family, and the impact on relationships both within the family and with others. I would also like to discuss your views about secrecy or openness with respect to the use of donor gametes within your family, and the ways in which these issues are dealt with by you, and other family members.

If you agree to take part in this study, you will have one interview with Katrina Hargreaves which will take about an hour. This will take the form of a guided conversation. With your permission, the interview will be taped and later transcribed. Should you wish, you may receive a copy of the interview transcript for comment before it is analysed. The purpose of the interview is to gather information and not to offer advice or comment. However, if any issues or questions arise for you as a result of the interview, you can be referred to someone who will be able to provide information that may assist you. I recognise that this topic is private and personal. Therefore, you are encouraged to discuss only matters you feel comfortable talking about. You may withdraw from the interview or from the entire project at any time.

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#### Information for Health Professionals

You are invited to participate in the above-named research project, which is being undertaken by Katrina Hargreaves. This is an exploratory study which looks at the effect on families of having a baby by donor insemination or donation of eggs. The purpose of the interview is to explore the role of health professionals in the practice of using donor gametes in assisted reproduction. Issues that I wish to explore in the interview include: your role at the clinic; the extent to which donor gametes are used in assisted reproduction in your clinic; the processes recipients of donor gametes go through during the course of their treatment; and any guidance or advice given on the possible implications for families of having a baby through the use of donor gametes. I am interested in discussing your clinic's position on secrecy and openness, and informing the child of his/her genetic origins, how the clinic maintains donor anonymity and acts as an intermediary between donors and recipients and their children.

Participation in this study involves one interview with Katrina which will take approximately one hour. With your permission, the interview will be taped and later transcribed. Should you wish, you may receive a copy of the interview transcript. You have the right to withdraw from the interview or from the entire project at any time.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this interview. Katrina will be the only person to have access to any identifying information about the participants in this research. To ensure anonymity and confidentiality, tapes will be kept in a locked filing cabinet, and at no time will the names of participants be revealed. Pseudonyms will be used in the publication of any of the interview material, and any identifying information will be changed to ensure complete confidentiality. Tapes will be erased or returned to you after transcription if you wish.

Katrina Hargreaves can be contacted at the University of Canterbury, telephone (03) 364-2987 extn. 7375. She will be pleased to discuss any concerns you may have about participation in the project. The supervisors for this exploratory study are:

Dr Jan Cameron  
Department of Sociology  
Private Bag 4800  
Christchurch  
Telephone: (03) 364-6186

Associate Professor Ken Daniels  
Department of Social Work  
Private Bag 4800  
Christchurch  
Telephone: (03) 364-6447

Jan Cameron has published books and articles on issues to do with families, and people's motivations to have children, or to remain childfree. With over 60 published papers on topics concerned with assisted human reproduction, Ken Daniels is an internationally-recognised researcher in this area. This project has been reviewed and approved by the National Ethics Committee on Assisted Human Reproduction.



## CONSENT FORM

### **The Use of Third Party Gametes in Assisted Reproduction: An Exploratory Study of the Implications for 'Family'**

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the study, and I consent to publication of the results of the research with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Researcher

## APPENDIX B

- NUDIST nodes

PROJECT: DONOR, User Katrina, 1:12 pm, Mar 9, 2001.

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(1) /Pathways
(1 1) /Pathways/Deciding
(1 1 1) /Pathways/Deciding/Reasons
(1 1 2) /Pathways/Deciding/Delays
(1 1 3) /Pathways/Deciding/Methods
(1 1 4) /Pathways/Deciding/FM-awareness
(1 2) /Pathways/Infertility
(1 2 1) /Pathways/Infertility/Tests
(1 2 2) /Pathways/Infertility/Response
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(1 2 3) /Pathways/Infertility/Issues
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/Treatment/Information/Tracking cycles  
 /Treatment/Inseminations  
 /Treatment/Inseminations/Success rates  
 /Treatment/Pregnancy-Birth  
 /Treatment/Followup  
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 /Relationships/Grandparents  
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 /DI child/Concerns  
 /DI child/Comparisons  
 /DI child/Issues

## APPENDIX C

### Fertility clinic information:

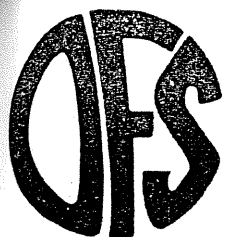
- Treatment price lists
- Semen donation
- Semen storage
- Donor insemination treatment programme
- Treatment options and their success
- Donor insemination clinical care pathway
- Infertility counselling service

## To all patients of the Fertility Centre;

The following table covers the pricing adjustments that will shortly take place. If you have any concerns or questions related to it, please feel free to call at any time. Please note also that where price increases for cycles of treatment are concerned, the new price is applicable for cycles where the 'booking on' day falls on or after the first of June 1998 (ie calling in with day 1 of your cycle for treatment).

Service / Treatment	Price	Date of change	Other details
First Visit Appointments	\$ 100.00	No Change	
Follow Up Appointments	\$ 55.00	June 1, 1998	all appointments from that date
Donor Insemination Cycles	\$ 450.00	June 1, 1998	all cycles commenced from that date*
DI new appointments	\$ 185.00	June 1, 1998	all appointments from that date
Intrauterine Insemination Cycles	\$ 320.00	June 1, 1998	all cycles commenced from that date*
Donor IUI Cycles	\$ 500.00	June 1, 1998	all cycles commenced from that date*
Ultrasound scans	\$ 30.00	June 1, 1998	all scans from that date
Counselling (not cycle related)	\$ 50.00	No change	
Trial Semen Freeze	\$ 125.00	June 1, 1998	
Semen Storage	\$ 125.00	No change	Per annum, invoiced 6 monthly
Embryo Freezing	No charge		
Embryo Storage	\$ 125.00	No change	
IVF new appointments	\$ 150.00	No change	
IVF cycles	\$4,400.00	July 1, 1998	All cycles booked from that date *
IVF cycles with Gonal-F recombinant medication	\$4,900.00	July 1, 1998	All cycles booked from that date *
Administration fee for cancelled IVF cycles	\$ 195.00	July 1, 1998	All cycles booked from that date * Does not include medication charge.
ICSI (additional to IVF)	\$1,500.00	July 1, 1998	All cycles booked from that date *
Donor Oocyte (additional to IVF)	\$1,100.00	July 1, 1998	All cycles booked from that date * Known donor only. For unknown donor price please ask.
Frozen Embryo Thaw (failed thaw, no transfer)	\$ 240.00	No change	
Frozen Embryo Thaw and Transfer	\$ 420.00	July 1, 1998	All cycles booked from that date *
Percutaneous Epididymal Sperm Aspiration (PESA)	\$ 600.00	No change	
Testicular Sperm Extraction (TESE)	\$ 450.00	No change	
Microsurgical Epididymal Sperm Aspiration (MESA)	\$ 250.00	No change	(Lab Support of procedure only)
LH Testing Kits	\$ 10.00	No change	
Semen Analysis	\$ 63.00	No change	
Semen Washing	\$ 115.00	No change	
Post Coital Test	\$ 18.00	No change	
Post Coital Test & Consult	\$ 73.00	June 1, 1998	all appointments from that date
Book - My Story	\$ 18.00	No change	

Out of town patients please feel free to call 0800 4 FERTILITY (0800 433 784).



# Otago Fertility Services

Incorporating IVF Otago

Dunedin Hospital, Dunedin, New Zealand

Telephone (03) 474 7752, Facsimile (03) 474 7620

## FEEES FOR ASSISTED REPRODUCTIVE

### TECHNOLOGY PROCEDURES

(as from 1 July 1998)

<u>IVF Using Standard Dose Metrodin</u>	\$3,900
<u>IVF Using Standard Dose Puregon / Gonal F</u>	\$4,250
<u>ICSI Using Standard Dose Metrodin</u>	\$4,500
<u>ICSI Using Standard Dose Puregon / Gonal F</u>	\$4,900
<u>Embryo Freezing</u>	\$400
<u>Embryo Thaw</u>	\$650
<u>Embryo Thaw With Transfer</u>	\$900
<u>IUI</u>	\$550
<u>Donor IUI</u>	\$550
<u>DI</u>	\$500
<u>Post Coital Test</u>	\$125

ALL PRICES INCLUDE GST

There will be an additional charge for any extra drugs used above the maximum normally required.



HEALTHCARE  
OTAGO  
LIMITED

Private Bag 1921  
Dunedin, New Zealand  
Telephone 03 474 0999  
Facsimile 03 474 7623

## PAYMENT OF CHARGES

HealthCare Otago asks that patients who wish to pay off their accounts make their arrangements in advance of treatment. No credit will be extended if the arrangement has not been completed prior to the commencement of treatment.

The terms for payment are as follows:

25% deposit to be paid on receipt of invoice.

The remainder to be paid off within 6 months of the invoice.

We do allow some negotiation of this time frame, however credit will not be extended beyond 12 months.

Should you wish to make this arrangement you are asked to call to the Accounts Department on the first floor of the Ward Block. Our office is at the end of the corridor overlooking the one way system. The contact people are Kevin Gould ext 5172 and Clare Mackenzie ext 8418.



No donor's identity will be divulged to either recipient or child without the donor's prior consent. However we hope that donors consider being available to meet any children who desire it, when the children reach adulthood. This 'managed' meeting would be arranged through a third party.

### **Number of successful pregnancies**

The use of any donor's semen is restricted to four families. Recipients quite often ask if it is possible to have the same donor for another child, and where possible we try to reserve some samples for this purpose. Therefore each family may have more than one child.

The donor may choose to restrict the use of his semen to fewer than four families.

### **Hereditary diseases**

Because the clinic is responsible for protecting the interests of children conceived by DI it is important that the clinic is advised of any relevant medical information that becomes known by the donor at a later stage; so it can be passed on to any resulting children. For instance the discovery of a family history of a mild blood clotting disorder, or heart attacks at an early stage, would be considered relevant information to pass on.

We also need to be advised if a donor dies at a relatively young age.

### **Important factors to consider**

- The successful donor is the biological father, and his children are half brothers or sisters, to at least one other child in the community.
- There is a possibility that at least one child may wish to trace their genetic link to the donor in the future.
- Because of the above, the donor needs to consider telling his children, at a suitable age, of his participation in the DI programme.

If you have any questions, the receptionist, Janine, is available to refer you on to the most appropriate person. Janine can be contacted 8.30 - 5.00pm weekdays, ph 364 4622.

The Fertility Centre

New Zealand Centre for Reproductive Medicine Ltd  
885 Colombo Street, Private Bag 4711, Christchurch  
New Zealand. Tel: 0-3 364 4622. Fax: 0-3 364 4634

## **Semen Donation**

The Donor Insemination Programme is intended to help people with infertility due to male factors. Only frozen semen, which is thawed before insemination, is used.

**To select suitable donors we need the following:**

- To protect the interest of any resulting child - proof of identity i.e. drivers licence or passport.
- A thorough medical and family history.
- A declaration of health from your GP.
- A full sexual health assessment with the Sexual Health Clinic.
- A physical examination, urine and blood samples are required to screen for Hepatitis B & C, HIV(AIDS) antibodies and CMV (Cytomegalovirus).
- A semen analysis and trial freeze of a sample. The trial freeze is necessary because not all semen freezes well.
- Donors must be prepared to be identified by any resulting children at some appropriate later stage, under managed circumstances.

If all of the above requirements are met, the donor is invited to join the DI programme.

Because of the personal and social issues involved with DI the donor and his partner are seen together to discuss the responsibilities and implications of being a semen donor (i.e. the importance of being truthful when providing information, and the possibility of being contacted in the future by children wanting to trace their biological origin). The purpose of this meeting is to ensure both parties have an opportunity to ask questions and discuss issues relating to the DI programme.

The donor and his partner are required to sign a form consenting to supply semen for the DI Programme.

Each donor is asked to complete a questionnaire of personal, non-identifying information about himself to be used for couples selecting donors. A copy of that non-identifying information will also be provided for any resulting children.

It is also probable that the government will establish a New Zealand register of children born from donor sperm or eggs, with the identity of their donor. Donors are known to couples by code numbers only. (All information provided complies with the information privacy principles in the Privacy Act 1993).

Four or five specimens of semen are then quarantined for six months, after which the donor has another blood test to check his blood is still clear of evidence of HIV, and Hepatitis B & C. The semen is used only if these tests are negative.

After the initial donations, donors often provide an additional four or five samples over the next three or four years to meet recipients' requests for full siblings.

**Who uses the programme?**

Originally the programme was set up for couples with male infertility, however the Human Rights Act requires that single women and lesbian couples now also be provided treatment.

**What rights are there for donors?**

The Human Rights Act requires the clinic to offer DI without discrimination, but as the donor is making a gift, he is free to choose where his gift goes.

Donors decide whether their semen is to be available for married couples, de-facto couples, single women or lesbian couples.

If the donor wishes, we will advise him when a successful pregnancy results from his donation.

**The legal status of the donor**

If a woman conceives as a result of Donor Insemination, the legal father of her child is her male partner.

The Status of Children Amendment Act (1987) says the donor does not have the rights or liabilities (including financial) of a father.

**Information regarding the donor**

Because we believe that DI children have the right of access to information about their genetic heritage, all recipients are encouraged to tell the children of their origins.

We collect extensive non-identifying information: height, weight, eye and hair colour, educational background, occupation, interests and an extensive family medical history. Women who conceive are given a printout of the donor's non-identifying information for the resulting child/children.

### Using your frozen sperm

The procedure for using your stored frozen sperm is relatively simple. We normally check that your partner is ovulating by taking a blood sample seven days after the approximate time of ovulation. If it appears that your partner is ovulating, then on the insemination cycle your partner brings early morning urine samples to the lab, starting a few days before ovulation is expected. On the day that Luteinizing hormone (LH) is detected in the urine (LH is the hormone necessary to trigger ovulation), your partner is inseminated.

This involves a short visit to the clinic during which the Insemination Nurse inserts a speculum into the vagina and inserts your thawed sperm into the cervix. This is not a painful procedure and after a short rest your partner can resume her normal activities.

With good sperm and a fertile woman conception is likely to occur within three cycles (in fact 24% of our Donor Insemination patients conceive on the first cycle), but there are no guarantees. It can take longer and may involve more intensive treatment.

**If you have any questions, the receptionist, Janine, is available to refer you on to the most appropriate person. Janine can be contacted 8.30 - 5.00pm weekdays, ph 364 4622.**

**The Fertility Centre**

New Zealand Centre for Reproductive Medicine Ltd  
885 Colombo Street, Private Bag 4711, Christchurch  
New Zealand. Tel: 0-3 364 4622, Fax: 0-3 364 4634

Semen Storage

October, 96

**The Fertility Centre**

New Zealand Centre for  
Reproductive Medicine Ltd

## Semen Storage

Vasectomy involves cutting the vas deferens, the tube which transports sperm from the testes into the ejaculate.

In theory vasectomy can be reversed, however sometimes the ends of the vas are damaged so that reconstruction is impossible. Some men form antibodies to sperm after their vasectomy. The antibodies infiltrate the seminal fluid and attach to the sperm, making the sperm incapable of fertilising oocytes (female eggs).

Vasectomy should be considered a permanent form of contraception, but some people may wish to reduce the finality of a vasectomy by storing sperm as a form of insurance against circumstances that would make them want a vasectomy reversal.

University of Otago and HealthLink South Joint Venture

### **Semen Analysis and Freezing**

If you wish to store semen, a semen sample is collected, analysed and frozen. This is to check whether your semen will survive freezing and thawing, because not everyone's semen can be frozen, then thawed successfully.

If your semen survives the trial process, then a number of samples would be frozen prior to your vasectomy. The number of inseminations needed to insure a reasonable chance of pregnancy can be calculated, and this will determine the number of samples required (usually three).

### **Storage conditions**

- Any potential recipient of stored semen must meet the Centre's criteria for treatment before insemination can take place.
- Semen can be stored for up to 10 years, providing the annual storage fee is paid. The storage fee is to be paid in advance.
- The semen belongs to the man who provided the sample (not the couple).
- If and when the semen owner decides he no longer wants semen stored on his behalf he is required to sign a declaration that he no longer wishes to have his semen stored, witnessed by a clinic staff member, and the semen will be disposed of.
- In the event of the semen owner's death the semen will be disposed of.
- It is the responsibility of the semen owner to advise the clinic of any changes in address.
- Should a storage fee annual account not be paid when due, clinic staff will attempt to contact the semen owner at his last address recorded by clinic staff. If attempts to contact the owner are unsuccessful the semen will be disposed of one year after the last unpaid account, unless the semen donor contacts the clinic and pays the outstanding amount in the meantime.

### **Charges**

The charges for semen storage are based on the period of time and the number of samples stored.

The current charges for sperm storage are:

Assessment and freeze per sample	\$100.00 (GST incl)
Storage per annum	\$125.00 (GST incl)

Please bring payment for each sample for assessment and freezing, with the sample.

### **Procedure**

Please make an appointment with one of the nurses, Kay or Lindsay, telephone 364 4625.

The nurses will go over potential problems, procedures and charges. They will also discuss your partner's fertility history to help decide on the number of insemination cycles that may be required, and therefore the number of semen samples that should be stored.

The nurses will go through the consent form and witness your signature on it.

You will be given : a copy of the consent form  
instructions for producing samples  
directions for making an appointment for freezing

Follow the instructions for producing a sample to ensure the best quality sample possible. Before bringing in a sample, make sure you have an appointment with Tina or Mary in the lab, telephone 364 4549.

Not all semen freezes and thaws satisfactorily. Tina or Mary will call you with the result of the first freeze and discuss the need for further samples, or advise you that your semen is not suitable for freezing.

Welcome to the Donor Insemination Programme.

We hope you will find this leaflet helpful in understanding the programme and procedures.

We would like to remind you to please ensure you have settled your account with us at each stage of your treatment. The stages for this are - following your initial assessment and before beginning each treatment cycle.

Thankyou

Otago Fertility Service  
HealthCare Otago



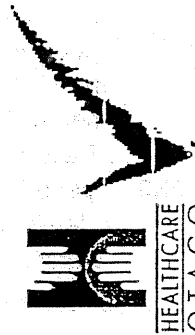
*Otago Fertility Services*

Incorporating IVF Otago

Dunedin Hospital, Dunedin, New Zealand

Telephone (03) 474 7752, Facsimile (03) 474 7620

# Donor Insemination Treatment Programme



doing the best for you



# Insemination Pathway



doing the best for you

	Pre-treatment Phase	First Treatment Phase	Options review	Second Treatment Phase	Third Treatment Phase
	VISITS	Appointments with the Clinic Nurse for treatment. Attend appointment for a scan	Appointment with Doctor.	Appointments with the Clinic Nurse for treatment.	Appointments with the Clinic Nurse for treatment.
	INDICATIONS	Folic acid which reduces the incidence of Spina Bifida. It can be bought from your local Pharmacy			
	INVESTIGATIONS	Blood screening, a pelvic ultrasound. Record details of period. Observe fertile phase eg increase in mucus (clearplan).	In the first cycle you will need to have a scan at around day 10 of your cycle	Reassessment with your Doctor which may include a laparoscopic investigation (visual inspection fallopian tubes etc)	Usually you will not need further investigations
	DIET	Normal diet			
	HYGIENE	You may bath or shower during your treatment			
	ACTIVITY AND REST	If you smoke, you will be advised that smoking will reduce the chances of becoming pregnant.	Continue with your normal physical and sexual activities		
	EDUCATION	Discuss treatment with Doctor. Discuss the procedures with the Nurse. Discuss how you feel about the treatment programme with the Doctor and the Counsellor. Read written information	Learn how to identify your fertile phase either by mucus or using Clearplan (urine test). Please remember our Counsellor is available for consultation throughout your treatment.		
	TREATMENTS	Please remember to record all of your period dates	There are usually 3 cycles in each treatment phase. On the first day of your period you will need to phone the Clinic Nurse. Treatment occurs over 1-2 days (or longer) during your most fertile phase of each cycle.	Some people may benefit from intra-uterine insemination (IUI). This option will be discussed with you.	Options review



**Table C1 Treatment Options and their Success**

<u>Treatment</u>	<u>When is this an option</u>	<u>Average success rates</u>
<b>IVF</b> (in vitro fertilisation)	IVF may be used for every type of infertility, except where the quality or quantity of sperm is reduced.	World wide figures indicate an average success of 14-15% per treatment cycle. This means that most couples will not have a success unless they are able to have more than one cycle. Australasian figures show the overall success after 3 treatments is 37% and after 6 treatments it is 56%. Remember these figure are averages - the real results for you will depend on a number of factors listed in the next two Tables
<b>DI</b> (donor insemination)	DI is used for any condition where the sperm numbers are absent or of poor quality. In these cases ICSI (see below) may also be used.	We expect approximately 30% of women to conceive by the end of the 3rd treatment. In our programme from 1984 to 1992, 63% of women had conceived by 12 cycles
<b>ICSI</b> (intra cytoplasmic sperm injection)	Is used in any situation where there are insufficient sperm available for conventional IVF.	When ICSI first became available, it was thought that the success rate may be better than for IVF. However this does vary on where the sperm comes from and whether there is sperm motility or not. The overall success rate is similar to that obtained by IVF.
<b>IUI</b> (intrauterine insemination)	This treatment is used for many reasons - the most common being where the man has a low or poor sperm count. Sometimes it is used for ejaculation disorders, or even in couples with unexplained infertility.	The success of IUI will vary depending on the quality and numbers of sperm that can be inseminated. In cases of ejaculation problems (e.g retrograde ejaculation) we can expect up to a 25% chance with one treatment. In men with poor sperm quality the chance of pregnancy may be extremely low. Your chances will be estimated following each treatment cycle, and you will be advised whether to change to another treatment.
<b>HMG treatment</b> (gonadotrophins)	HMG is usually used for women who do not ovulate or who do not respond to simpler ovulation drugs. Sometimes HMG is used in IUI treatments.	In conditions where women do not ovulate or do not have a period, HMG can be highly successful, up to 25% per treatment cycle. However, if the woman's ovaries are malfunctioning the chance can be quite low. It is important that you discuss your chances with your doctor.

**Table C2 Comparison of IVF success rates with age of woman**

The chance of success is dependent on the age of the woman, and can be measured in many ways. For example, a 30 year old woman who starts an IVF cycle has an overall chance of a baby of 16.9%. But this takes into consideration that some 30 year olds have no chance because they do not stimulate sufficiently to get any eggs or they do not get any embryos to transfer back into the uterus. Therefore the actual chance of a woman who has an embryo transferred is higher - 21.6%. The following Table gives this information for all age groups (source: Templeton et al, 1996)

Age	Live-birth per treatment cycle	Live-birth per egg collection	Live-birth per embryo transfer
25	19.9	22.0	25.4
30	16.9	18.5	21.6
35	13.9	15.4	17.6
40	8.2	9.4	11.0
45	2.5	3.3	3.9

## Donor Insemination Pathway

**Commencement date:**

Attach Patient Label Here

**Discharge date:**

This Clinical Care Pathway has been developed by Senior staff at HealthCare Otago as a plan of care for 70-80% participating in the Donor Insemination programme. It is to be used as a guide only and where clinically indicated can be overridden. Clinical pathways aim to assist clinicians in measuring and improving clinical outcome. Revised Nov 1997

## Pathway Track

When all critical criteria are ticked please asterix on the graph at the corresponding stage and day

<b>When all critical criteria are met</b>					
<b>Discharge Phase</b>	Satisfaction survey completed	Options discussed			
<b>Third Treatment Phase</b>	Options discussed	Counselling offered			*
	Undergone first IUI/cervical treatment	Undergone second IUI/cervical treatment			
	Undergone third IUI/cervical treatment	Reassessment Completed			
<b>Second Treatment Phase</b>	Options discussed	Counselling offered		*	
	Undergone first IUI/cervical treatment	Undergone second IUI/cervical treatment			
	Undergone third IUI/cervical treatment	Reassessment Completed			
<b>First Treatment Phase</b>	Undergone first intracervical treatment	Undergone second intracervical treatment		*	
	Undergone third intracervical treatment	Reassessment Completed			
<b>Pre-Treatment Phase</b>	Tests completed	Issues counselling completed		*	
	Education completed and consent signed	Donor selected			
<b>Screening</b>	DI to proceed		*		

**Day**      ▲

**Actual Day** ▼

**Dates**

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20
---------	---------	---------	---------	---------	---------	---------	---------	---------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------

The dotted line on the graph shows the expected timeframe and progress for patients in the DI programme. There will be some people who may fall to the right of the "expected track" indicating their time in the programme is taking longer than expected.

**Specimen Sign**

Specimen Sign					
Initials	Name (print)	Des	Initials	Name	Design



Patient Label

### Pre-Treatment Phase

## Variation

N/A


## Variations

[illegible]

NB Some patients may take longer than one day for this stage. This patient must meet the required criteria outlined on the front sheet graph, to advance to the next stage.

## Donor Insemination Clinical Care Pathway

Patient Label

Treatment Phase _____										* Variation  N/A			
Code		Medical						1		2		3	
M1		Reassessment following treatment phase completed											
M2		Further tests ordered											
M3		Laparoscopic tests ordered											
Code		Nurse Coordinator						1		2		3	
N1		Phone call when period starts											
N2		Dominant follicle observed in scan											
N3		Adequate mucus											
N4		Given Clearplan											
Code		Nursing Cont...						1		2		3	
N5		Patient continuing with Treatment											
N6		Procedures completed											
N7		Account sent											
N8		RUS documentation completed											
		Counsellor						1		2		3	
C1		Seen for counselling											
C2		Further counselling sought											

## Variations

[illegible]

## Donor Insemination Clinical Care Pathway

Patient Label

Treatment Phase _____								* Variation <input type="checkbox"/> N/A <input type="checkbox"/>	
Code	Medical	1	2	3	Code	Nursing Cont...	1	2	3
M1	Reassessment following treatment phase completed				N5	Patient continuing with Treatment			
M2	Further tests ordered				N6	Procedures completed			
M3	Laparoscopic tests ordered				N7	Account sent			
Code	Nurse Coordinator	1	2	3	N8	RUS documentation completed			
N1	Phone call when period starts				Counsellor				
N2	Dominant follicle observed in scan				1	2	3		
N3	Adequate mucus				C1	Seen for counselling			
N4	Given Clearplan				C2	Further counselling sought			

## Variations

[illegible]

## Donor Insemination Clinical Care Pathway

Patient Label

### Outcome from Treatment

Initial/\* Date

N1	Normal pregnancy
N2	Gone onto IVF
N3	Withdrawn from treatment
N4	Counselling used


## On-Discharge Checklist

Initial/\* Date

N5	Customer satisfaction survey completed
N6	Account written up and sent to accounts
N7	Saved straws for subsequent use


## Variations

[illegible]

# Otago Fertility Service Clinical Care Pathway

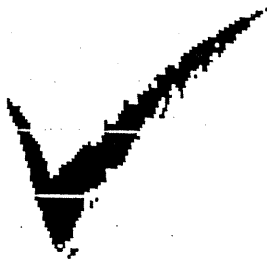


*Otago Fertility Services*

Incorporating IVF Otago

*Dunedin Hospital, Dunedin, New Zealand*

*Telephone (03) 474 7752, Facsimile (03) 474 7620*



doing the best for you

## **The Fertility Centre Counselling Service**

*We aim to offer a confidential, professional service for clients of The Fertility Centre.*

*We are accountable for the quality of our service through our professional association and the management of The Fertility Centre.*

### ***Anna Thorpe***

Bachelor of Social Work (Hons)

Member NZ Assoc. of Social Workers

CQSW

### ***Jan Barrett***

Dip. Social Work

Member NZ Assoc. of Social Workers

CQSW

(Members of ANZICA -  
Australia NZ Infertility Counsellors  
Association - )

**Tel: 364 4821 (Anna)  
or 364 4440 (Jan)**

*Management contact :*

*Mark Leggett, Business Manager;  
3644 868 or (025) 587 843*

# *The Fertility Centre*

*at Christchurch Women's Hospital*

*Private Bag 4711  
885 Colombo Street  
Christchurch*

**The Fertility Centre**

*at Christchurch Women's Hospital*

**INFERTILITY  
COUNSELLING  
SERVICE**

**The New Zealand Centre for Reproductive Medicine Ltd**  
A joint venture of the University of Otago & Healthlink South Ltd

## What Infertility Means

Infertility is a common medical problem with strong emotional implications for those whom it affects.

Sometimes surrounded by families who ask about their plans for children, and by friends who seem to have no problems conceiving and bearing babies, these people can experience traumatic feelings of loss, grief, inadequacy and envy. Sometimes people find it hard to admit that they have a fertility problem, and secrecy about the problem is common. This further isolates them from friends, family and partners.

Within relationships, strain can result in blame and mistrust of each other for what they feel is an inexplicable failure at something that should be so "natural". Not surprisingly, they may experience communication problems, sexual difficulties and increasing emotional disruption.

Treatment itself can be very stressful, relentless and expensive. Couples must make many complex decisions about what treatment to have, how to fit it into their lives as easily as possible, and when to move on from treatment.

## How can an Infertility Counsellor help?

Feelings of depression, anger, isolation and jealousy, together with loss of control, loss of self-esteem and loss of health may all be part of being infertile. Major grief reactions can be triggered by failed and cancelled treatment cycles, early pregnancy loss, fear of pregnancy loss or advancing maternal age.

Counselling can help with these stresses, provide support, information and an opportunity to explore disturbing feelings. It can often help couples address some of the complex issues relating to their treatments.

Counselling can also assist in decision making regarding treatment methods and suggest ways for couples to develop strong and affectionate relationships with appropriate goals for their future lives.

**Complex issues do require opportunities to discuss them as fully as possible.**

If either parent is not genetically related to the child - for instance if donor gametes have been used or if the child has been adopted - there may be further issues, including the complex question of how and when to inform the child of his or her origins.

## Who is infertility counselling for?

This service is for people using the following services of The Fertility Centre;

- Infertility Investigations
- In Vitro Fertilisation (IVF)
- Donor Egg
- Donor Insemination (DI)
- Ovulation Stimulation and Intra-Uterine insemination (IUI)

Everyone going through the IVF, Donor Egg, or Donor insemination programmes needs to see a counsellor before they start.

This is not an assessment, but rather an opportunity to be prepared for what the programme involves and what it might mean personally.

It is a free service for most people, although private counselling is available on request.

Any private counselling (outside the services provided by The Fertility Centre), is charged at \$50.00 per hour (GST inclusive).

**Certain programmes at the Centre require a counsellor's appointment before you start.**

## APPENDIX D

- RTAC guidelines



## ATTACHMENT E

### GUIDELINES FOR THE STORAGE AND USE OF GAMETES AND EMBRYOS

1. Gametes should not be taken for the treatment of others from female donors over the age of 35 nor from male donors should over the age of 55 unless there are exceptional reasons for doing so. If there are exceptional reasons, these should be explained in the treatment records.
2. Gametes taken from women over 35 and men over 55 may be used for their own treatment, or the treatment of their partner.
3. Gametes should not be taken for the treatment of others from anyone under the age of 18.
4. Sperm or oocytes *must not* be taken from anyone who is not capable of giving a valid consent or who has not given a valid consent.
5. The possibility of donating gametes or embryos should not be raised during a patient's treatment cycle. Donation should be discussed before treatment is commenced so that the patient's views are not coloured by the situation during the course of treatment.
6. Information must be given to people donating or using stored gametes or embryos on the following points:
  - 6.1 the procedures involved in collecting gametes, the degree of pain and discomfort and any risks to that person eg. from the use of ovarian stimulation drugs;
  - 6.2 the screening which will be carried out and the practical implications of having an HIV antibody test;
  - 6.3 the purposes for which their gametes or embryos might be used;
  - 6.4 State law regarding the legal status of children born as a result of the procedure;
  - 6.5 whether or not State law permits donors to preserve their anonymity;
  - 6.6 the information which centres collect and the extent to which that information may be disclosed to people born as a result of the donation;
  - 6.7 that they are free to withdraw or vary the terms of their consent at any time, unless the gametes or embryos have already been used;
  - 6.8 the possibility that a child born disabled as a result of a donor's failure to disclose defects, about which he or she knows or ought reasonably to have known, may be able to sue the donor for damages.
  - 6.9 in the case of oocyte donation, that the woman will not incur any financial or other penalty if she withdraws her consent after preparation for oocyte recovery has begun;
  - 6.10 that donated gametes and embryos created from them normally will not be used for treatment once the number of families in which children have been born from then has reached 10 or any lower figure specified by the donor; and
  - 6.11 that counselling by specialist infertility counsellors is mandatory.
7. Anyone consenting to the storage of their gametes, or of embryos produced from them must:
  - 7.1 specify the maximum period of storage (if this is to be less than a statutory storage period);
  - 7.2 state what is to be done with the gametes or embryos if he or she dies, or becomes incapable of varying or revoking his or her consent.
8. Centres should ensure that people do not feel under any pressure to give their consent.

9. If the donated gametes are to be used for treatment and the donor is married or has a long-term partner, centres should encourage donors to ask their partner to consent in writing to the use of the gametes for treatment.
10. In the case of oocyte donation, the centre should be prepared to accept the financial loss if the woman withdraws consent after preparation for oocyte recovery has begun.

**11. *Oocytes, Sperm and Embryos not to be used for Treatment***

- 11.1 Treatment centres should ensure that sufficient scientific evidence is available to establish that any therapeutic procedures used do not prejudice the development potential of the gametes or embryos.
- 11.2 Oocytes, sperm or embryos which have been subjected to procedures which carry an actual or substantial theoretical risk of harming the development potential of embryos should not be used for treatment.
- 11.3 Gametes or embryos which have been exposed to a material risk of contamination which might cause harm to recipients or children should not be used for treatment. If there is any doubt, centres should seek expert advice.
- 11.4 Women must not be treated with the gametes or with embryos derived from the gametes of more than one man or woman during any treatment cycle.

**12. Termination and Disposal**

- 12.1 Where an embryo is no longer to be kept for treatment, the centre should decide how it is to be disposed of. The procedure should be sensitively devised and described and the people for whom the embryo was being stored should be notified if they so wish.
- 12.2 In the case of embryos used for research, the timing and method for terminating development before fourteen days or (if earlier) the appearance of the primitive streak, must be part of the protocol approved by the Research and Ethics committees.

Acknowledgment: A number of the above Guidelines have been derived from the Human Fertilisation and Embryology Authority: Code of Practice : London.

*November 1992, revised March 1997.*

## ATTACHMENT F

### GUIDELINES FOR CONSENT FORMS

RTAC suggests the following guidelines for the preparation and use of Consent Forms. All consent forms should be consistent with relevant State laws and regulations and approved by an Institutional Ethics Committee.

1. There should be a request by the patients for a procedure to be carried out.
2. While a general consent form covering relevant procedures may be acceptable, it is preferred that only one procedure is to be consented to on each form. Use a separate form (and a separate signature) for each extra option which may be consented to, for example: IVF, GIFT, donor oocytes, donor sperm, donor embryos, embryo freezing, oocyte freezing, oocyte donation to another woman, oocyte donation for research, semen donation to another couple, embryo donation to research, or embryo donation to another couple.
3. The form is to be signed by both partners, witnessed and dated.
4. There should be an acknowledgment that there has been an exchange of information regarding the procedure between the patients and the medical practitioner and that the patients have had adequate time and opportunity to ask questions about the procedure and its risks and that all questions have been answered to the patients' satisfaction.
5. There should be an acknowledgment that the patients have been given detailed written information about the procedure.
6. There should be an acknowledgment of the risks and possible side effects or complications of the procedure.
7. There should be an acknowledgment that the procedure may be cancelled or unsuccessful.
8. There should be a clear statement as to whether the clinic views the procedure as a standard therapeutic procedure or as experimental, innovative therapy or a clinical trial. This is particularly important when new techniques are being introduced.
9. There should be an acknowledgment that the patients are free to withdraw their consent at any time.
10. Indemnities releasing the Centre and its directors and employees from liability for negligence should not be included.

*November 1992, revised March 1997.*

## **ATTACHMENT J**

### **GUIDELINES FOR SCREENING FOR GAMETE DONATION**

RTAC considers the following as the minimum criteria for semen and oocyte donor programs. These criteria are for screening and selection of donors.

#### **1. History**

History is taken for:

- 1.1 Family history of inherited disorders.
- 1.2 Personal history of physical, mental or psychological disabilities.
- 1.3 All donors must sign a lifestyle declaration as required by the relevant State Department of Health or, if there is no such legal requirement, in terms similar to those set out below.

#### **2. Physical Examination**

Physical examination for:

- 2.1 obvious abnormalities, especially hereditary diseases and infections
- 2.2 recording physical characteristics for matching.

#### **3. Semen Analysis**

Detailed semen analysis for:

- 3.1 potential fertility
- 3.2 signs of infection which require further investigation.

#### **4. Oocyte Examination**

- 4.1 Microscopic examination of oocytes after collection for normality

#### **5. Serology**

The following serological tests must be performed:

- 5.1 Blood group and Rh (and any other blood group antibodies).
- 5.2 Syphilis serology - VDRL or similar.
- 5.3 Hepatitis B surface antigen and hepatitis C antibodies
- 5.4 HIV 1 & 2 antibodies.

**NB** Repeat serology for syphilis, hepatitis B & C and HIV should be performed on a regular basis when donations are being repeated.

In the light of current information, sero-conversion to HIV will occur within six months of infection. When gametes are frozen or are fertilised and the embryos are frozen, it is necessary to test donors six months after each donation to *clear* donation of HIV infectivity. Opportunity should be taken to carry out repeat screens for syphilis and hepatitis B&C. Centres may prefer to hold material for longer periods before re-testing.

#### **6 Genetic Tests**

Genetic tests of either or both the donors and recipients should be considered depending on local circumstances. For example:

Thalassaemia - in Mediterranean Europeans or Asians, Thalassaemia trait can be screened by the measurement of haemoglobin and mean corpuscular volume.

Tay-Sachs Disease - in Jews, this autosomal recessive trait is present in 1:50 Aschkenazi Jews (in America) .

Cystic Fibrosis - in Caucasians, the common mutations such as delta F508 are present in about 1 in 25 Caucasians.

Detailed genetic profiles of these and other less common defects are likely to become commercially feasible in the near future. In those places where there is a legal requirement to provide identifying information about the donor to the offspring, storage of DNA may be worth while for confirmation of paternity.

## **7. Bacteriology**

7.1 Donated semen should be cultured periodically, including specific culture for *Niesseria gonorrhoea*.

7.2 Cultures for communicable diseases, including chlamydia and herpes should be taken from the female genital tract of the donor prior to the time of oocyte collection.

## **8. Recording of Screening Information**

Screening information on donors must be retained.

## **9. Physical Characteristics**

The following information should form part of the donor record.

9.1 height

9.2 build

9.3 eye colour

9.4 hair colour

9.5 skin colour

9.6 race

## **10 Social History**

It is considered appropriate to record the following non-identifying donor information which may be of assistance to parents of children at a later date.

10.1 age

10.2 religion

10.3 nationality of donor and donor's parents and grand parents

10.4 race of donor and donor's parents and grand parents

10.5 country of birth of donor and donor's parents and grand parents

10.6 schooling

10.7 occupation

10.8 marital status

10.9 number of children

10.10 interests (hobbies, sports etc)

10.11 comment on donor personality by interviewer

10.12 reason for donating gametes

## **11. Confidentiality**

- 11.1 Care should be taken to avoid any disclosure of patient or donor identifying information, except with their written consent or in those cases where the donor is a volunteer known to the recipient.
- 11.2 Identifying information regarding donors should be retained as confidential records within the ART Centre or donor collecting Centre.
- 11.3 Donors and recipients must be informed of relevant State legislation regarding transfer of identifying information.
- 11.4 Donors known to the recipient must not participate if State or Hospital regulations preclude this.

## 12. Withholding Period

- 12.1 Donated semen must be cryopreserved and quarantined for six months and the HIV test repeated on the donor. If negative, the semen may be used for insemination. Fresh semen must not be used for donor insemination.
- 12.2 Donated oocytes should be fertilised with the husband's or donor semen and the embryos cryopreserved for six months. Embryo transfer may be performed after repeat HIV tests on the oocyte donor is negative. It is strongly recommended that this should be the preferred method for oocyte donation.

## 13. Fresh Oocyte Donation

- 13.1 The use of fresh oocyte donation with embryo formation and embryo transfer should only be performed after full discussion of the respective risks of HIV transmission by the use of fresh and frozen/thawed embryos. The donor must have been tested for HIV, and hepatitis B and C within a few days before treatments leading to oocyte collection begin.
- 13.2 Many recipients may assume that in the case of donors *known to them* the element of risk of HIV infection is negligible. This cannot be presumed lightly and doctors facilitating oocyte donation should ensure personally that recipients understand the implications of the respective procedures before signing the consent form. The desirability of using frozen/thawed embryos in all patients should be considered.

14. Mixing of oocytes from donors is prohibited and mixing of semen from donors is prohibited.

15. There must be no direct or covert coercion of a prospective donor and there must be no monetary or valuable consideration or other inducement for donation.

Out of pocket expenses and any medical expenses incurred in respect of gamete donation may be reimbursed by the recipients.

16. In the case of women undergoing oocyte collection for their own treatment, it is considered unethical to hyperstimulate with the objective of deliberately obtaining an excessive number of oocytes/embryos so that some become available for donation.

17. The attached lifestyle declaration has been recommended in one State and is similar to that used by a blood transfusion service. A similar declaration should be used for semen and oocyte donation.

18. Copies of information sheets for patients, consent forms and lifestyle declarations must be submitted to RTAC for comment and approval. (see attached **DONOR LIFESTYLE DECLARATION** approved by RTAC 19th July, 1991.)
19. Counselling of donors and their spouses is required.
20. Donors should be given the opportunity to direct or limit the use of their material to certain categories of recipients, for example heterosexual couples, or specific cultural and religious groups.

*October 1991, revised November 1992, March 1997, September 1998.*

## APPENDIX E

- Information for sperm donors
- Semen donation
- Sperm donor non-identifying information forms
- Questionnaires on semen use
- Donor newsletter



# OTAGO FERTILITY SERVICES

## INFORMATION FOR SPERM DONORS

### Why do we need sperm donors?

Some couples are unable to achieve a pregnancy either because of low sperm numbers or total absence of sperm in the male partners ejaculate. In some cases the male partner has a genetic abnormality. For some of these couples artificial insemination using donor semen is a treatment option should they wish to have a family.

Recruitment of new donors is an ongoing problem for most hospitals and clinics which offer donor insemination. Lack of donor semen often leads to long waiting times for treatment which can make an already stressful situation even more difficult to cope with.

Couples undergoing this treatment rely on people like you and they are extremely grateful for the chance you are giving them.

### Who may become a sperm donor?

We need reliable, responsible men from all walks of life. You should be aged from twenty to fifty years and suffer from no serious medical disability. Your family must be free from any known inherited or familial disorders.

### Who should not become a sperm donor?

Any person who could potentially pass on a hereditary disease must NOT donate semen

Many serious infectious diseases (e.g. HIV and hepatitis) are transmitted through blood and semen. Any person who is suffering from an infectious disease or who has had sexual contact with anyone who is known or suspected to be carrying HIV must NOT donate semen.

In addition, any person who is an intravenous drug user must NOT donate semen.

### How do we determine your suitability to be a donor?

All potential donors are interviewed. Your physical characteristics will be recorded and you will be required to fill out a number of forms which will include your medical history and a family history of inherited disorders. You will also be asked to provide non-identifying information which is used to help recipients decide which donor they will use.

When this is completed you will be asked to provide a semen sample to enable us to determine the quality of your semen and to see how well your sperm survive freezing and thawing. Poor sperm survival prevents as many as 50% of men who apply from becoming donors. At this point semen is also tested for the presence of chlamydia.

NB: (~~semen samples may be produced at home or a room is available at our clinic~~).

If your semen sample is satisfactory you will be asked to provide a blood sample. Your blood group will be determined and your blood will be tested for hepatitis B, hepatitis C, HIV and syphilis. You will also be required to attend a clinic for a physical examination.

Finally, as all donors are asked to consider whether they are willing to be identified you will be asked to attend an interview where this and other issues will be discussed. Your partner is invited to attend this interview and we hope it will help you both to make an informed decision.

#### Legal issues:

The Status of Children Amendment Act of 1987 recognises the social father (i.e. the husband of the woman who receives the semen) as the legal father of the child. Clause 5, 2(b) states that

*"the man who produced the semen used in the procedure shall not have the rights and liabilities of a father of any child of the pregnancy, either born or unborn, unless at any time the man becomes the husband of the woman."*

There are no laws covering the running of donor insemination programmes in New Zealand. However, Otago Fertility Service follows the guidelines set down by the Australian Reproductive Technology Accreditation Committee (ARTAC) and is examined at regular intervals by the committee.

#### Confidentiality:

All our files are confidential and no information will be released without your consent. Similarly, you will have no access to information about the person who receives your sperm.

#### What information can I have?

If you wish, we will inform you of the number of pregnancies you have had and the sex of the children. We will not give you any details of when or where the births have occurred.

#### What are my responsibilities?

We ask all donors to inform us of any change in health status during or immediately following the period of donation (e.g. if they are diagnosed with or have put themselves at risk of contracting diseases such as HIV, hepatitis, syphilis or other STD's)

We also ask that donors keep us informed of any change of address

#### Who do I contact?

Your contact at Otago Fertility Service is

Gaylene Lloyd.

Monday - Thursday, 9.30am-1.30pm

Phone -(03) 4740999 ex8575 or (03) 4747752



## SEMEN DONATION

Thank you for your interest in the donor insemination programme. The University Department of Obstetrics and Gynaecology uses the semen from fertile donors to help couples with infertility due to male causes. This is done by artificially inseminating the woman with frozen semen. If the woman conceives then the legal father of her child is her partner and the donor is absolved from the responsibilities and rights of parenthood. Donors are known to couples only by code numbers. We collect extensive non-identifying information (such as height, weight, eye and hair colour, educational background, interests and hobbies) which is given to couples. Couples are encouraged to tell the children of their origins, and we hope most donors will consider being available to meet any children should they desire it when they reach adulthood. However, no donor's identity will be divulged to either couple or child. We envisage any future contact being organized through a third party.

For the successful donor this means that there is at least one child in the community unknown to him but for whom he is the biological father and who is a half brother or sister to any of his own children. We limit the number of successful couples to any one donor to five, but each couple may have more than one child. We will tell the donor the results of his donations if he would like to know.

We ask donors to use discretion as regards the way they talk about their role in the programme. Always remember that the people you are talking to may be recipients.

Not every man is a suitable semen donor either because he has a potential hereditary or infectious disease or his semen does not stand up to the freezing process. For some reason some men's sperm are more easily damaged by freezing than others.

To get the most suitable donors the assessment includes:

- 1 The taking of a thorough medical and family history, paying particular attention to hereditary disease and infectious disease. Men with the potential to pass on hereditary or infectious disease, in particular sexual diseases such as AIDS, would not be encouraged to progress further.

- 2 In an effort to reduce the likelihood of any sexually transmitted disease we would appreciate a visit to the Sexual Health Clinic for a physical examination with a doctor. This will also include a blood test for Hepatitis B, C, HIV, Syphilis and a urine sample for Chlamydia.
- 3 Semen analysis for sperm count and then freezing of semen is performed. The semen can be produced at home and brought into the department. If the return of live sperm after thawing is adequate, then the donor is accepted and invited to sign a consent form, along with his wife if he is married (this protects the donor against future differences of opinion.)
- 4 Three or four specimens of semen are then stored for six months when the donor has another blood test, this time for evidence of AIDS infection. The test is delayed for six months because some men may take time to show a positive blood test. Only when this test is done and negative would the semen be used.
- 5 Because the programme depends on the help and honesty of the donor, we are unable to pay for semen donations. In some situations payment for semen may be seen to encourage the withholding of important information.
- 6 Each donor is asked to fill in a form of personal non-identifying information for the successful couple.

We will be happy to discuss any questions or worries you may have. It is important that potential donors ask questions and don't participate if they have serious doubts.

## SPERM DONOR

### NON IDENTIFYING INFORMATION

Many parents whose child is conceived by donor insemination plan to tell their child about their conception.

The following form provides this child with NON IDENTIFYING information about their paternal genetic background.

This is the only information that recipients will receive unless you consent to release further information.

**Please read carefully:**

I declare that I have completed this form myself and that the information I have given is true and correct.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## DONOR NON IDENTIFYING INFORMATION

Donor No: \_\_\_\_\_

Age: \_\_\_\_\_

Married: Yes ☐ No ☐

Children: Yes ☐ No ☐

No of Boys: \_\_\_\_\_

No of Girls: \_\_\_\_\_

### Physical Characteristics:

Eye colour \_\_\_\_\_

Hair colour \_\_\_\_\_

Hair type \_\_\_\_\_

Build \_\_\_\_\_

Complexion \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Religion \_\_\_\_\_

Ethnic Group \_\_\_\_\_

Nationality \_\_\_\_\_

Country of Birth \_\_\_\_\_

♦ **Describe yourself** (eg out going, placid, moody, sensitive, quiet, extroverted, etc)

---

---

♦ **How do you get on with others** (parents, friends, workmates)

---

---

♦ **Level of education reached** (Primary, Secondary, Tertiary)

---

---

♦ **List subjects most enjoyed**

---

---

♦ **Present Occupation**

---

---

♦ **Previous Occupation(s)**

---

---

♦ **Do you have any special talents**

---

---

♦ Interests / Hobbies

---



---

♦ Future goals / Ambitions

---



---

♦ Do you enjoy good health? (If no, please detail)

---



---

♦ Have you ever had any operations? (If yes, please detail)

---



---

♦ Are you allergic to anything? (Penicillin, bee stings, pollen, dust, etc)

---



---

♦ Do you smoke?

Yes ☐

No ☐

♦ Do you drink?

Socially / Moderate / Heavy

**FAMILY HISTORY**

**Mother**

Eye colour 

---

Height 

---

Original hair colour 

---

Build 

---

Complexion 

---

Nationality 

---

Ethnic origin 

---

Occupation (past or present) 

---

Interests 

---

**Father**

Eye colour 

---

Height 

---

Original hair colour 

---

Build 

---

Complexion 

---

Nationality 

---

Ethnic origin 

---

Occupation (past or present) 

---

Interests 

---

**Grandparents**

Mothers mother 

---

Mothers father 

---

Fathers mother 

---

Fathers father 

---

**Nationality**

---



---



---



---

**Ethnic Group**

---



---



---



---

**Brothers and Sisters**

Sex	Age
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
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**Height (short, medium, tall)**

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**Occupation / Interests**

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♦ Any other comments you would like to make about yourself (eg important influences)

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♦ Why did you want to become a donor?

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Finally, many parents intend to tell their children the facts about their conception.

If the children or their parents would like further information about you or wish to make contact with you they are asked to contact the staff at the Otago Fertility Services.

If this should occur would you be willing for Otago Fertility Services to contact you and ask you to consider their request.

Yes ☐

No ☐

If yes, what would you consider to be the right time (childs age etc)

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## DONOR NON-IDENTIFYING INFORMATION

Most couples whose child is conceived by Donor Insemination plan to tell their child the nature of their conception. To help with this, the Donor Insemination Programme supplies some non-identifying information to the couple.

This form, when filled in by you, will be typed and only this information will be given to recipient couples if requested. If the information you give is too specific, then it may be possible for recipient couples to identify you. One of the clinic staff will discuss any questions or worries you have.

Please complete the following statement:

I declare that I have completed this form myself and the information is true and correct.

.....  
Signature

.....  
Date

## DONOR NON-IDENTIFYING INFORMATION

This information will be supplied with your permission to potential recipient couples

Age Group: 20-25 - 26-30 - 31-35 - 36-40 - 41-45 - 46-50

Marital Status: \_\_\_\_\_

Number of existing children: \_\_\_\_\_ Boys: \_\_\_\_\_ Girls: \_\_\_\_\_

Eye colour: \_\_\_\_\_ Complexion: \_\_\_\_\_

Hair colour: \_\_\_\_\_ Type of hair: \_\_\_\_\_

Amount of hair: \_\_\_\_\_ Do you tan easily: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Build: \_\_\_\_\_ Country of birth: \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_ Time in N.Z: \_\_\_\_\_

Religion: \_\_\_\_\_ Practising Yes / No

How would you describe yourself?  
(outgoing, placid, moody, sensitive, jolly, quiet, extroverted etc)

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How do you get on with other people?

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### Education:

Primary  
Secondary

School Cert  
6th Form Cert  
Bursary

Yes / No  
Yes / No  
Yes / No  
Yes / No

Tertiary Degree (s) \_\_\_\_\_

Diplomas/Certificates \_\_\_\_\_

Did you like school? \_\_\_\_\_

Favourite subjects: \_\_\_\_\_

What is your occupation? \_\_\_\_\_

What other jobs have you had? \_\_\_\_\_

What would you like to do in the future? \_\_\_\_\_

What do you do during your spare time? \_\_\_\_\_

What sporting activities have you enjoyed in the past, and to what extent did you excel at them?

Do you play any musical instruments or have an interest in any particular types of music?

Do you have good health?

Yes / No

If no give details: \_\_\_\_\_

Have you had any operations?

Yes / No

If yes give details: \_\_\_\_\_

Are you allergic to anything? (Penicillin, bee stings etc) \_\_\_\_\_

Do you have any known food allergies - (please state): \_\_\_\_\_

Do you have good vision? Yes / No

Do you wear glasses/contact lenses? Yes / No Astigmatism/Short sighted/Long sighted

Do you smoke? Yes / No How many? \_\_\_\_\_

Do you drink alcohol? Yes / No Heavy / Moderate / Occasional

### FAMILY HEALTH HISTORY

Please describe you family members by the following characteristics if known:

	Mother	Father	Mothers mother	Mothers father	Fathers mother	Fathers father
Eye Colour						
Hair Colour						
Complexion						
Height						
Body Type						
Vision						
Nationality						
Ethnic Group						
Occupation						
Approx Age						

How many brothers do you have? \_\_\_\_\_

How many sisters to you have? \_\_\_\_\_

Have any twins or multiple births occurred in your family? Yes / No

If yes, what relation to you? \_\_\_\_\_

Please list below at what age members of your family died and what was the cause of their death, please be as specific as possible.

Relation	Age at time of death	Cause of death
Grandmother (Mothers)		
Grandfather (Mothers)		
Grandmother (Fathers)		
Grandfather (Fathers)		
Mother		
Father		
Brothers 1.		
2.		
3.		
Sisters 1.		
2.		
3.		

Why do you want to be a donor? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other comments you would like to make about yourself?

(eg important influences / experiences in life) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any comments from your partner? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If children or their parents wish to make contact with you in the future, would you be willing to consider their request?

Yes / No

What kind of contact would you feel comfortable with?

Direct meeting / Letter / Through third party

When would you consider was the right time (age of child etc)?

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## Questionnaire on semen use

Donor.....

How do you feel about your semen being for recipients in the following categories

(Please tick the most appropriate answer)

	very uncomfortable	uneasy	indifferent	comfortable	completely comfortable
Single women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lesbian couples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Criminal record	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Married couple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
De facto couple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Different ethnic background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Are there any categories that you don't want your semen used for? i.e. do you wish to withdraw consent to use your semen for some particular categories? (either mentioned above or of your own choosing)

\* refer psychiatric problem/criminal record  
regarding previous child abuse convictions/links.

Would you be interested in receiving non-identifying information on successful couples?

Would rather  
not know

Not interested

Mildly interested

Very interested

# Questionnaire on semen use

Partner of Donor.....

How do you feel about your partner's semen being used for recipients in the following categories:

(Please tick the most appropriate answer)

	very uncomfortable	uneasy	indifferent	comfortable	completely comfortable
Single women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lesbian couples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Criminal record	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Married couple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
De facto couple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Different ethnic background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Are there any categories that you don't want your partner's semen used for? i.e. do you wish to withdraw consent to use his semen for some particular categories? (either mentioned above or of your own choosing)

*Persons who have had previous history of child abuse e.g. charged & convicts of sexual abuse.*

Would you be interested in receiving non-identifying information on successful couples?

Would rather

Not interested

Mildly interested

Very interested



## Christchurch Donor Insemination Programme

Donor's Newsletter December 1995

For most of 1995 we've not had enough donors available to be able to take on all the couples wanting our help, so our waiting list has been growing again. However the last few months has seen the six month quarantine period passed for a number of new donors who joined us earlier in the year and the situation is now much improved. We've been wanting to reduce the number of couples per donor for some time, and have taken this opportunity to change it so that each donor may only father families for four couples. Of course this means that we still need more donors...!

It's likely that in the future there'll be fewer couples using donor insemination. The Christchurch IVF Unit has just ordered a micromanipulator which makes it possible to inject single sperm into human eggs. This technique, known as ICSI (IntraCytoplasmic Sperm Injection) has had extremely good success rates in other clinics. Thus even a man with an extremely low sperm count, who would have little chance of achieving a pregnancy with normal IVF, may be able to father his own children with the assistance of ICSI. However ICSI is expensive, probably of the order of \$5,000 per cycle, and it can easily take four or five cycles to achieve a pregnancy. Also, in cases where the cause of the infertility is unknown, there is a very real risk that there is a mutation in the genes controlling sperm production which would be inherited by any son such a man may have. So I think there is still a long term place for donor insemination, though probably the number of couples requesting it will reduce.

I'm sure most of you are well aware that we like donors to be prepared to be contacted by the donor children when they reach adulthood (which we've tentatively defined as 18). As the oldest children are about 7 that's still a way off. In the meantime we have the problem of establishing some form of long-term contact so that, maybe 20 or more years after your donation, we can still find you. One way of achieving this would be through your family solicitor. We're still working on the details, but I expect to be contacting you over this in the new year (perhaps with the next newsletter to save on postage). For those of you who joined the programme with the guarantee of anonymity, if that is what you still want then your wishes will be respected. Couples have always been told whether particular donors are available for contact, so will know if their donor does not want contact.

For a few numbers: In the eight years I've been involved with the programme we have had 254 conceptions for 186 babies delivered. 103 of these were boys and 83 girls and the overall conception rate is 15.5% per cycle. On their first cycle 21% of couples conceive and after 3 cycles 43% of couples will had a conception. I'll include a printout of your own individual details with this newsletter. Do let me know if you can see any inaccuracies - sometimes the computer seems to get confused.

Thank you again for your help. We greatly appreciate all the co-operation we get from donors, and the understanding from their partners.

Merry Christmas and all the best for 1996.

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